NATIONAL PACIFIC DENTAL, INC.

Evidence of Coverage
DHMO Dental Plan

IMPORTANT INFORMATION REGARDING YOUR PLAN

We are licensed as a Health Maintenance Organization offering a single health care service plan. Should any provision herein not conform to the Texas Health Maintenance Organization Act or other applicable laws, it shall be construed as if it were in full compliance thereof.

IMPORTANT NOTICE

You may call our toll-free telephone number for information or to make a complaint at 1-866-528-6072.

You may also write to:

Grievances and Appeals
PO BOX 25187
Santa Ana, CA 92799-5187

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at (800) 252-3439.

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
FAX#: (512) 475-1771

PREMIUM OR CLAIM DISPUTES:

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

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Usted puede llamar nuestro número de teléfono de peaje-liberta para la información o para formular una queja en 1-866-528-6072.

Usted también puede escribir a nosotros en:

Grievances and Appeals
PO BOX 25187
Santa Ana, CA 92799-5187

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de companies, coberturas, derechos o quejas al (800) 252-3439.

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax #: (512) 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Debele tiene una disputa con respecto a su prima o acerca de un reclamo usted nos debe contactar primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

ATAR ESTE AVISO A SU POLIZA:

Este aviso es solo para propósito de información y no se convierte en parte o condicion del documento adjunto.

Table of Contents

Evidence of Coverage

This Evidence of Coverage provides a detailed summary of how your Plan operates, your entitlements and the Plan's restrictions and limitations. However, this Evidence of Coverage constitutes only a summary of the Dental Plan. Your Organization's Dental Plan Contract must be consulted to determine the exact terms and conditions of coverage. If the agreement or certificate contains any provision not in conformity with the Insurance Code Chapter 1271 or other applicable laws, it shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the Insurance Code Chapter 1271 and other applicable laws.

Entire Contract

We typically contract with an Organization, such as your employer or association, to offer benefits to its employees or members. Your Organization's contract with us, together with the application, acceptance agreement, Enrollment Form, this Evidence of Coverage and any attachments or inserts, constitutes the entire agreement between the parties. To be valid, any change in the contract must be approved by an officer of our company and attached to it. No agent may change the Contract or waive any of the provisions. Should any provision herein not conform to applicable laws, it shall be construed as if it were in full compliance thereof.

Who May Enroll

Your Organization determines how you may become eligible to join the Plan. You may enroll yourself and your dependents provided each meets your Organization's eligibility requirements and the Service Area and Dependent Coverage requirements listed below.

Service Area

The Service Area is the geographical area in which we have a panel of Contracted Dentists who have agreed to provide care to our members (see page [19] for a map of the service area). To enroll in our Plan, you must reside, live, or work in the Service Area, and the permanent legal residence of any enrolled dependents must be:

- the same as yours;
- in the Service Area with the person having temporary or permanent conservatorship or guardianship of such dependents, including adoptees or children who have become the subject of a suit for adoption by the enrollee, where the Subscriber has legal responsibility for the health care of such dependents;
- in the Service Area under other circumstances where you are legally responsible for the health care of such dependents; or,

- in the Service Area with your spouse

Eligibility

Employees

You are in an Eligible Class if you are a regular full-time officer or employee working at least 32 hours per week and your Employer has determined that your place of residence is within the Service Area covered under this Plan. Your Eligibility Date, if you are then in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the first day of the calendar month coinciding with or next following the date you complete a probationary period of 90 days of continuous service for your Employer or, if later, the date you enter the Eligible Class. You can remain in an Eligible Class as a retired employee if you retire under your Employer's IRS Qualified Retirement Plan and will receive a pension, except a deferred vested pension. You may continue your Health Expense Coverage and any coverage you have for your dependents. If you retired before the Effective Date of this Plan, you are also in an Eligible Class. You must follow the Enrollment Procedure. You may have Health Expense Coverage for you and your dependents.

Dependents

"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.

Enrollment Procedure

Initial Enrollment

You will be required to enroll in a manner determined by your Employer. This will allow your Employer to deduct your contributions from your pay. Be sure to enroll within the same calendar year of the qualifying event.

Your contributions toward the cost of this coverage will be deducted from your pay and are subject to change. The rate of any required contributions will be determined by your Employer. See your Employer for details.

Late Enrollment

A "Late Enrollee" is a person (including yourself) for whom you do not elect Health Expense Coverage within the time same calendar year of the qualifying event.

If you do not enroll during the Initial Enrollment Period, you and your eligible dependents may be considered Late Enrollees and coverage may be deferred until the next annual open enrollment period established by your Employer. If at the time of your initial enrollment, you elect coverage for yourself only and later request coverage for your eligible dependents, they may be considered Late Enrollees.

You must enroll within the time period prescribed by your Employer before the end of the next annual late entrant enrollment period established by your Employer.

Coverage for a Late Enrollees will become effective on the "coverage begin date" set by the county auditor. However, you and your eligible dependents may not be considered Late Enrollees under the circumstances described in the "Special Enrollment Periods" section below.

Special Enrollment Periods

A person, including yourself, will not be considered to be a Late Enrollee if all of the following are met:

- You did not elect Health Expense Coverage for yourself or any eligible dependent during the Initial Enrollment Period (or during a subsequent late enrollment period) because at that time:
  i. the person was covered under another group health plan or other health insurance coverage; and
  ii. you stated, in writing, at the time you refused coverage that the reason for the refusal was because the person had such coverage, but such written statement is required only if your Employer requires the statement and gives you notice of the requirement;

and the person loses such coverage because:

i. loss of eligibility for Medicare, Medicaid or CHIP
ii. it was provided under a COBRA continuation provision, and coverage under that provision was exhausted; or
iii. it was not provided under a COBRA continuation provision, and either the coverage was terminated as a result of loss of eligibility for the coverage, including loss of eligibility as a result of:
- legal separation or divorce;
- death;
- termination of employment;
- reduction in the number of hours of employment;
- the employer's decision to stop offering the group health plan to the Eligible Class to which the employee belongs;
- cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
- the operation of another Plan's lifetime maximum on all benefits, if applicable; or
iv. employer contributions toward the coverage were terminated.

- You elect coverage within the same calendar year of the date the person loses coverage for one of the above reasons.

In addition, you and any eligible dependents will not be considered to be Late Enrollees if your Employer offers multiple health benefit plans and you elect a different plan during the open enrollment period established by your Employer.

Also, the following persons will not be considered to be Late Enrollees given any of the following circumstances:

- You, if you are eligible, but not enrolled, and your newly acquired dependents through marriage, birth, adoption, or placement for adoption. However, you must request enrollment for your newly acquired dependent(s) and yourself, if you are not already enrolled, within the same calendar year of the marriage, birth, adoption, or placement for adoption.
- Your spouse from whom you are separated or divorced, or child who would meet the definition of a dependent, if you are subject to a court order requiring you to provide health expense coverage for such spouse or child. However, you must request enrollment within the same calendar year of the court order.

Coverage will be effective on the date determined by your Employer:

i. in the case of marriage, on the date the completed request for enrollment is received;
ii. in the case of a newborn, on the date of birth;
iii. in the case of adoption, on the date of the child's adoption or placement for adoption;
iv. in the case of court ordered coverage of a spouse or child, on the date of the court order;
v. in the case of loss of coverage under COBRA continuation, on the date COBRA continuation ended; and
vi. in the case of loss of coverage for other reasons, the date on which the applicable event occurred.

Effective Date of Coverage

Employees

Your coverage will take effect on your Eligibility Date as determined by your Employer.

Dependents

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage. You should report any new dependents. This may affect your contributions. If you do not do so within the same calendar year of the qualifying event, coverage will take effect as provided in the Late Enrollee section of this Summary of Coverage.

Note: This Plan will pay a benefit for Covered Medical Expenses incurred by a newborn child during the first 31 days of life, whether or not the child is or becomes enrolled under the Plan.

If the child does not become enrolled under the Plan, coverage will terminate at the end of such 31 day period. Any Extension of Benefits provision will apply. The Continuation of Coverage under Federal Law provision will not apply.

Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- you make written request for coverage for the child within the same calendar year of the date the child is placed with you for adoption.

Coverage for the child will become effective on the date the child is placed with you for adoption if the written request to enroll the child is within 31 days the child is “placed for adoption.” If request is not made within 31 days of the qualifying event, coverage for the child will be subject to all of the terms of this Plan.

Special Rules Which Apply to a Child Who Must Be Covered Due To A Qualified Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after the date your coverage becomes effective. You must make written request for such coverage. Coverage for the child will become effective on the date specified by your Employer.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

Receiving Care

When you enroll in our Plan, you must choose a Selected General Dentist from our extensive network. Please refer to the *Directory of Participating Dentists* for a complete listing of network dentists.

Making an Appointment

Once your coverage begins, you may contact the Selected General Dentist you chose at enrollment or is assigned to you through Customer Service to schedule an appointment. Our Contracting Dental Offices are open in accordance with their individual practice needs. When scheduling an appointment, please identify yourself as one of our members. Your Selected General Dentist will also need to know your chief dental concern and basic personal data.

Arrive early for your first appointment to complete any paperwork. Your first visit to your Selected General Dentist will usually consist of x-rays and an exam only. By performing these procedures first, your dentist can establish your treatment plan according to your overall health needs.

We recommend that you take this brochure with you on your appointment, along with the enclosed *Schedule of Benefits*. Remember, only dental services listed in the *Schedule of Benefits* and provided by your Selected General Dentist are covered.

Specialty Referrals

During the course of treatment, your Selected General Dentist may encounter situations that require the services of a dentist limiting his/her practice to specialty care, as defined in this Evidence of Coverage. Your Selected General Dentist will provide you with a Specialty Referral Form outlining what procedures need to be performed or evaluated by a Specialist. Contact us and we will advise you of the name, address, and telephone number of the dentist who will provide the required treatment. These services are available only when the dental procedure cannot be performed by the Selected General Dentist due to the severity of the problem. All referrals to a dentist whose practice is limited to specialty care must be authorized by us. Failure to follow the procedure regarding specialty referrals may result in services not being covered by us.

Out of Network Services

If medically necessary covered services are not available through our Network of Dentists, we shall, upon the request of a Network Dentist, within the time appropriate to the Enrollee's dental condition but not exceeding five (5) days, allow a referral to a non-network dentist, and shall fully reimburse the non-network dentist at the usual and customary fee, or an agreed-upon rate. Such referral shall not require the Enrollee to change his or her Selected General Dentist. Before we may deny a referral to a non-network dentist, we shall obtain a review of the Enrollee's dental condition by a Dentist of the same or similar specialty to that of the requested referral.

Changing Your Selected General Dentist

You have control over the Selected General Dentist you choose, and you can make changes at any time. If you need or desire to change your Selected General Dentist, please contact Customer Service at 1-866-528-6072. Our associates will help you locate a dentist most convenient to you. All transfers prior to the 20th day of the month will be effective on the first day of the month following the transfer request. All others will be effective the following month. In changing your Selected General Dentist, you may have to pay a fee for the cost of duplicating your x-rays and dental records.

In the event that your Selected General Dentist terminates his/her relationship with us for any reason, he/she must complete any treatment in progress. We will notify you by mail should your dentist terminate his/her agreement with us.

Second Opinions

At no cost to you, a second opinion may be requested if you have unanswered questions about diagnosis, treatment plans, and/or the results achieved by such dental treatment. Just contact our Customer Service Department either by calling 1-866-528-6072 or by sending a written request to the following address:

Grievances and Appeals
PO BOX 25187
Santa Ana, CA 92799-5187

In addition, your Selected General Dentist or we may also request a second opinion on your behalf.

All requests for a second opinion are processed within five (5) business days of receipt by us of such request. Upon approval, we will contact the consulting dentist and make arrangements to enable you to schedule an appointment. All second opinion consultations will be completed by a Contracting Dentist with qualifications in the same area of expertise as the referring dentist or dentist who provided the initial examination or dental care services. You may obtain a copy of the second dental opinion policy by contacting our Customer Service Department by telephone at the toll-free number indicated above, or by writing to us at the above address.

New Patient and Routine Services

As one of our members, you have the right to expect that the first available appointment time for new patient or routine dental care services is offered within three (3) weeks of your initial request. If your schedule requires that an appointment be scheduled on a specific date, day of the week, or time of day, the Contracting Dentist may need additional time to meet your special request.

Your Financial Responsibility
Monthly Prepayment Fee

Your Organization prepays us for your coverage on a monthly basis. If you are responsible for any portion of this Prepayment Fee, your Organization will advise you of the amount and how it is to be paid. The Prepayment Fee is not the same as a co-payment.

Co-payments

When you receive care from your Selected General Dentist, you will pay the co-payments described on your *Schedule of Benefits* enclosed with this brochure. When you are referred to a dentist that limits his/her practice to specialty care, your co-payment may be either a fixed dollar amount – or a percentage of the dentist's usual and customary fee. Please refer to the *Schedule of Benefits* for specific details. When you have paid the required co-payment, if any, you have paid in full. We do NOT require claim forms.

Claims

Claims are processed within 30 business days of receipt. Processing includes payment or denial of the claim, notification of investigation of the claim and requests for any additional information from the member that we reasonably believe necessary to resolve a claim. Not later than the 15th business day after receipt of all information necessary to process the claim, we notify the member in writing of acceptance or rejection of a claim. We give the reason(s) for a rejected claim; the reason for needing additional time to make a determination of a claim and we make payment of damages if payment on a claim is delayed following receipt of all necessary items. We will pay the claim, or part of the claim, not later than the 5th business day after notifying the member that the claim will be paid.

Customer Service

We provide toll-free access to our Customer Service Associates to assist you with benefit coverage questions, resolving problems, or changing your Selected General Dentist. Our Customer Service can be reached Monday through Friday at 1-866-528-6072 from 8:00 am to 5:00 pm Central Standard Time].

Emergency Dental Services

All of our contracted Selected General Dentists provide Emergency Dental Services twenty-four (24) hours a day, seven (7) days a week. In the event of a dental emergency and you are ***within*** seventy-five (75) miles of your Selected General Dentist, simply contact your selected dentist who will make reasonable arrangements for such emergency dental care.

If you are ***more than*** seventy-five (75) miles from your Selected General Dentist, or you cannot reach your Selected General Dentist or our Customer Service, you may obtain Emergency Dental Services from any licensed dentist.

We will provide coverage for the following Emergency Dental Services without regard to whether the dentist or provider furnishing the services has a contractual or other arrangement to provide services to covered individuals:

- Dental screening examinations or other evaluations required by state or federal law, which are necessary to determine whether an emergency dental condition exists.

- Necessary emergency dental care services, including the treatment and stabilization of an emergency dental condition.

- Services originating in a dental office following treatment or stabilization of an emergency dental condition, provided the treating dentist has made inquiry to and received authorization from us for the post stabilization services. We shall respond to the treating dentist within the time appropriate to the circumstances relating to the delivery of the services and the condition of the member but in no case to exceed one hour from the time of request.

Our Customer Service will request that you send a copy of the bill incurred as a result of such dental emergency to us. No claim forms are required. Please include your name, Social Security Number, address, and telephone number on all pages. After verifying the circumstances, we will reimburse you for the expenses for covered services, less any applicable co-payment, if a true emergency existed.

Examples of a dental emergency are defined as procedures administered in a dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

Dental Wellness Screening Program

If the contract holder has agreed to this program, you and/or your enrolled dependents may receive a wellness screening through specific dental screening locations, listed on the program collateral, which includes a review of an enrollee's health history as well as simple screening tests, such as blood pressure, blood glucose, oral soft and hard tissue, and/or body mass index (BMI), by which dentists will look for signs and risk factors for conditions, such as diabetes, heart disease or oral cancer, which can be connected to your oral health. Enrollees, and potentially their physician and primary dentist, will receive the findings, as well as counseling and materials on applicable conditions. There is no additional charge to the Enrollee for this screening. Please check our website for information on how to make a dental screening appointment. While this wellness screening program has been selected by the contract holder, enrollees are free to choose whether to receive a screening. The findings could result in referrals to physicians and dental specialists and may lead to earlier diagnosis and treatment, with the goal of improving health outcomes and lowering costs.

This program will be terminated, if: 1) it becomes cost prohibitive;, 2) the dental screening provider(s) opt out of the program and no suitable replacements are available ; 3) the number of participants in the program becomes excessive or too limited ; or 4) the program is found to be non-effective. This noninsurance wellness program may be terminated by us with a 60 day advance written notice to the contract holder.]

Complaint Procedures

A "Complaint" is your written or oral dissatisfaction about any aspect of our operation, including, but not limited to dissatisfaction with our plan administration; procedures, denial, reduction, or termination of a service for reasons not related to medical necessity; disenrollment decisions; or the way a service is provided.
A "Complaint" does not include (a) a misunderstanding or problem of misinformation that can be promptly resolved by us by clearing up the misunderstanding or by supplying the correct information to your satisfaction; or (b) you or your provider's dissatisfaction or disagreement with an adverse determination.

If you or one of your eligible Dependents has a complaint with us or your Selected General Dentist, you may register a complaint by calling our Customer Service at 1-866-528-6072.

Or you may submit a completed Verbal Complaint Form (available by calling the Customer Service number) or a written detailed summary of your complaint to us.

Grievances and Appeals
PO BOX 25187
Santa Ana, CA 92799-5187

Please be sure to include your Name (Patient's name, if different), Identification Number, Dental Facility (or Selected General Dentist) Name and Telephone Number on all written correspondence.

We agree, subject to our Complaint Procedure, to duly investigate and endeavor to resolve any and all complaints received from Members regarding the Plan. We will confirm receipt of your complaint in writing within five (5) business days of receipt of a complaint. We will resolve the complaint and communicate the resolution in writing within thirty (30) calendar days. You are also entitled to use the IRO process (Independent review) in the language of the major population if the enrollee has a disability affecting the enrollee's ability to communicate or read in the appropriate format including Braille, large print, audio tape, TDD access, or an interpreter. The HMO is prohibited from retaliating against a group contract holder or enrollee because the group contract holder or enrollee has filed a complaint against the HMO or appealed a decision of the HMO, and is prohibited from retaliating against a physician or provider because the physician or provider has, on behalf of an enrollee, reasonably filed a complaint against the HMO or appealed a decision of the HMO.

Appeals to Us

If we do not resolve your complaint to your satisfaction, you have the right to appeal our decision, either verbally or in writing, to our Complaint Appeal Panel. You may appeal by: (a) appearing in person before the Complaint Appeal Panel in a location where you normally receive dental services, or at a different location to which you agree; or (2) presenting a written appeal to the Complaint Appeal Panel. When you appeal your complaint:

(a) We will send an acknowledgement letter to you within five (5) business days after the date we receive your request for an appeal.

(b) We will appoint members to the Complaint Appeal Panel, which advises us on the resolution of the appeal. The members of the Complaint Appeal Panel cannot have been involved with your complaint in the past. The Complaint Appeal Panel will include an equal number of our staff, dentists, and enrollees (who are not employed by the HMO). The providers on the appeal panel must have experience in the area of care that is in dispute and must be independent of the provider who made any previous determination.

(c) Not later than the 5th business day before the Complaint Appeal Panel meets, we will provide to you or your designated representative:

(1) any documentation that will be presented to our participants of the Complaint Appeal Panel;

(2) the specialization of any Dentist consulted during the investigation of your appeal; and

(3) the name, specialty, and affiliation of each of the members of the Complaint Appeal Panel.

You, or your designated representative, if you are a minor or are disabled, have the right to:

(a) appear in person before the Complaint Appeal Panel;

(b) present alternative expert testimony; and

(c) request the presence of, and to question, any person that was involved in making the prior determination that resulted in your appeal.

We will complete the appeals process not later than the 30th calendar day after we receive your appeal. Our final decision on the appeal will include a statement of the specific dental determination, clinical basis, and contractual criteria used to reach the final decision.

If the appeal request involves a presently occurring dental care emergency, we will investigate and resolve such appeal in accordance with the degree of emergency of the case, but no later than one (1) business day after you have made your request for appeal. At your request, we will provide, instead of a Complaint Appeal Panel, an independent review by a Dentist who has not reviewed the case and who is of the same or similar specialty as ordinarily manages the procedure or treatment under appeal. The Dentist reviewing the appeal may interview you or your designated representative and will make a decision on the appeal. Initial notice of the decision on the appeal may be delivered orally to you but will be followed by a written notice of the determination within three (3) business days. Appeals for adverse determinations will be handled in the same manner.

Your failure to comply with these procedures, and the procedures outlined in the Member Rights and Plan Responsibilities provided with the acknowledgement letter, will result in the original decision being upheld, with no further action on such complaint.

Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve complaints through our complaint system process and who are dissatisfied with the resolution, may file a complaint with the Texas Department of Insurance at P.O. Box 149091, Austin, TX 78714-9091. The Department's telephone number is (800) 252-3439.

The Department's Commissioner will investigate a complaint against us to determine its compliance with insurance laws within sixty (60) days after the Department receives your complaint and all information necessary for the Department to determine compliance. The Commissioner may extend the time necessary to complete and investigation in the event any of the following circumstances occur: a) additional information is needed, b) an on-site review is necessary, c) we, the dentist or provider, or your do not provide all documentation necessary to complete the investigation, or d) other circumstances beyond the control of the Department occur.

Changes to Your Coverage
Renewing Your Coverage

Your Organization has contracted with us to provide services for the time period specified in the contract between the parties. Your coverage under the Plan is guaranteed for that time period so long as you meet the eligibility requirements under the Plan and the applicable Prepayment Fee has been paid. When the Contract expires, it may be renewed. If renewed, it is possible that the terms of the Plan may have been changed. If changes to benefits, co-payments or premiums have been made to a renewed contract, your Organization will notify you not less than sixty (60) days before the effective date.

Cancellation of Your Coverage

Your coverage may be cancelled after not less than 30 days written notice for:

- non-payment of amounts due under the contract, except no written notice will be required for failure to pay the Prepayment Fee.

- failure to establish a satisfactory dentist-patient relationship and if we have, in good faith, provided you with the opportunity to select an alternative dentist and you are notified in writing as least thirty (30) days in advance that we consider the dentist-patient relationship to be unsatisfactory and specifies the changes that are necessary in order to avoid termination, and you have failed to make such changes; in such case, coverage may be cancelled at the end of such thirty-day period.

- neither residing, living, or working in the service area or area for which we are authorized to do business.

Your coverage may be cancelled after not less than fifteen (15) days written notice for:

- an intentional misrepresentation, except as limited by statute.

- fraud in the use of services or dental facilities.

Your coverage may be cancelled immediately:

- subject to continuation of coverage and conversion privilege provisions, if applicable, if you do not meet eligibility requirements other than the requirements that you live or work in the service area.

- any misconduct detrimental to safe plan operations and the delivery of services.

Incontestability

All statements made on your Enrollment Form shall be considered representations and not warranties. The statements are considered to be truthful and are made to the best of your knowledge and belief. A statement may not be used in a contest to void, cancel, or non-renew your coverage or reduce benefits unless: (1) it is in a written enrollment application signed by you; and (2) a signed copy of the enrollment application is or has been furnished to your or your representative.

This contract may only be contested for fraud or intentional misrepresentation of material fact made on the enrollment application.

Termination Contract

When your employment with your Organization ends, your coverage ceases according to the rules of your Organization. Either we or your Organization may terminate the contract upon sixty (60) days written notice or upon its expiration date. If this happens, or the contract is not renewed, your membership in the Plan will be terminated according to the terms of the Contract. In the event of Contract termination, no further benefits will be provided to your and none of the Plan provisions will apply. We provide for a grace period of thirty (30) days for the payment of Prepayment Fees falling due, during which the coverage remains in effect. If your Organization fails to pay the Prepayment Fees through and including the final month of the contract, all coverage may be terminated at the end of such grace period, and you may be responsible for the usual and customary fees for services received from your Contracting Dentist during the period the Prepayment Fees went unpaid, including the grace period. Upon fifteen (15) days written notice to your Organization, your coverage may be terminated in the event of fraud on the part of the Organization.

Termination of Your Coverage

If you terminate from the Plan while the contract between us and your Organization is in effect, your dentist must complete any dental procedure started on you before your termination, abiding by the terms and conditions of the Plan. In addition to any other premiums for which the group contract holder is liable, the group contract holder is liable for an enrollee's premiums from the time the enrollee is no longer part of the group eligible for coverage under the contract until the end of the month in which the contract holder notifies the health maintenance organization that the enrollee is no longer part of the group eligible for coverage by the contract and that the enrollee remains covered until the end of that period.

In the case of a material change by the HMO to any provisions required to be disclosed to contract holders or enrollees pursuant to this chapter or other law, a group or individual contract holder may cancel the contract after not less than thirty (30) days written notice to the HMO.

Orthodontic treatment is governed by the Orthodontic Limitations listed on your *Schedule of Benefits*. If you terminate coverage from the Plan after the start of orthodontic treatment, you will be responsible for any additional incurred charges on any remaining orthodontic treatment.

Continuity of Care

For any enrollee whose Contracting Dentists has identified has having a "special circumstance" and requires ongoing care, we shall continue to cover the ongoing treatment of such enrollee, at not less than the rates and co-payments outlined on your Benefit and Co-payment schedule, upon termination of your coverage, for the condition identified in the "special circumstance." Our obligation to continue to cover the ongoing treatment shall not extend after the 90th ay after the effective date of the termination of your coverage, or nine (9) months after the effective date of the termination of coverage for enrollees diagnosed with a terminal illness at the time of termination of coverage.

For purposes of this provision, a "special circumstance" shall be defined as a condition regarding which the Contracting Dentist reasonably believes that discontinuing care by the Contracting Dentist could cause harm to the enrollee. By way of example, such "special circumstance" could include an enrollee with a disability, acute condition, or a life-threatening illness.

Conversion Privilege/Continuation of Coverage

Contact our Customer Service at 1-866-528-6072 to check availability of a Coverage Plan in your area. If your dental coverage is terminated for any reason other than involuntary termination for cause, you may elect to continue your coverage under contract, as provided by Texas law, which permits you to continue your coverage, upon payment of the applicable premium, until the earliest of (1) the date the maximum continuation period provided by law would end, which is: (A) for any enrollee not eligible for continuation coverage under COBRA (Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et. seq.)), the end of the nine-month period after the date the election to continue coverage is made; or (B) for any enrollee eligible for continuation coverage under COBRA, six additional months following any period of continuation provided under that statute; (2) the date on which failure to make timely payments would terminate

coverage; (3) the date on which you are covered for similar services and benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or any other plan or program; or (4) the date on which the group coverage terminates in its entirety. In addition, you and your eligible dependents are eligible to retain coverage in accordance with COBRA requirements and you and your dependents may be eligible for Medicare benefits. You must provide to the employer or group contract holder a written notice of election to continue group coverage no later than the sixtieth (60th) day after the later of (1) the date your coverage through your Organization would otherwise terminate; or (2) the date you are given notice of the right of continuation by your Organization. An enrollee electing continuation of group coverage must pay to the employer or group contract holder the amount of contribution required by the employer or group contract holder, plus an amount equal to two percent (2%) of the group rate for the coverage being continued under the group contract. The enrollee must make the payment no later than the forty-fifth (45th) day after the initial election for coverage and on the due date of each payment thereafter. Following the first payment made after the initial election for coverage, the payment of any other premium shall be considered timely if made by the thirtieth (30th) day after the date on which payment is due. At least thirty (30) days before the end of the continuation period described above that is applicable to the enrollee, we shall notify you that you may be eligible for coverage under the Texas Health Insurance Risk Pool. For purposes of this provision, "involuntary termination for cause" means: (a) termination for non-payment of Prepayment Fees, (b) termination for an intentional misrepresentation (except as limited by statute), (c) termination for fraud in the use of services or facilities, (d) termination for any misconduct detrimental to safe plan operations and the delivery of services; and (e) termination for failure to maintain the dentist-patient relationship.

Please contact your Organization for further information and details.

Principal Limitations and Exclusions

Below are the limitations that are applicable to this Plan:

1. Replacement of any crowns or fixed bridges (per unit) are limited to once every five (5) years;

2. Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such dentures under a National Pacific Dental, Inc plan. Replacements will be a benefit only if the existing denture is unsatisfactory and can not be made satisfactory as determined by the contracted general dentist;

3. Relines are limited to one every twelve (12) months;

4. Cleaning (prophylaxis) and fluoride treatments are limited to twice a year, unless medically necessary;

5. Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require a $125 copayment per unit in additional to co-payment for each crown/bridge unit;

6. There is a $75 copayment per crown/bridge unit in addition to regular co-payments for porcelain on molars;

7. An additional charge will be applied for any procedure using noble or high noble metal;

8. Panoramic or intraoral complete series, including bitewings (full mouth) x-rays are limited to once every three (3) years, unless medically necessary;

9. Sealant: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption, unless medically necessary;

10. Surgical removal of wisdom teeth/third molar for orthodontic reasons only is not a covered benefit;

11. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service;

12. Surgical removal of impacted teeth is not a covered benefit unless pathology [disease] exists;

13. The co-payments listed for endodontic procedures do not include the cost of final restorations.

The following dental procedures and services are not included in the Plan:

1. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescription or medication;

2. Dental services provided for or paid a federal or by state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare;

3. Dental services required while serving in the Armed Forces of any country or international authority or relating to a declared or undeclared war or acts of war;

4. Any dental services, or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the member's dental health, as determined by the contracted general dentist;

5. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen, or damaged due to abuse, misuse or neglect, unless otherwise specified as a covered service in the Schedule of Benefits;

6. Dental procedures initiated and completed prior to the member's eligibility under this plan or started after the member's termination from the plan;

7. Any procedure that is not specifically listed as a covered benefit in the Schedule of Benefits;

8. Dental procedures or services performed solely for cosmetic purposes or solely for appearance, unless otherwise specified as a covered service in the Schedule of Benefits;

9. Treatment of malignancies, cysts or neoplasms;

10. Orthognathic surgery;

11. General anesthesia;

12. Services considered unnecessary or experimental in nature;

13. Dental services received from any dental office other than our contracted dental office, unless expressly authorized in writing by us or as cited under "Emergency Dental Services"'.

14. Dental implant and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services;

15. Procedures, appliances, or restorations whose main purpose is to change the vertical dimension of occlusion, correct congenital, developmental, or medically induced dental disorders including, but not limited to treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specified as an orthodontic benefit on the Schedule of Benefits;

16. Dental procedures or appliances for minor tooth guidance or for the control of harmful habits such as thumb sucking and tongue thrusting.

Orthodontic Exclusions and Limitations (if a covered benefit under your plan)

I. Orthodontic treatment must be provided by one of our contracting dentists

II. Plan benefits shall cover 24 months of usual and customary orthodontic treatment and an additional 24 months of retention. Treatment extending beyond such time periods will be subject to a per-office-visit charge of $25 dollars.

III. The following are not included as orthodontic benefits:

1. repair or replacement of lost or broken appliances

2. re-treatment of orthodontic cases

3. treatment in progress at inception of eligibility

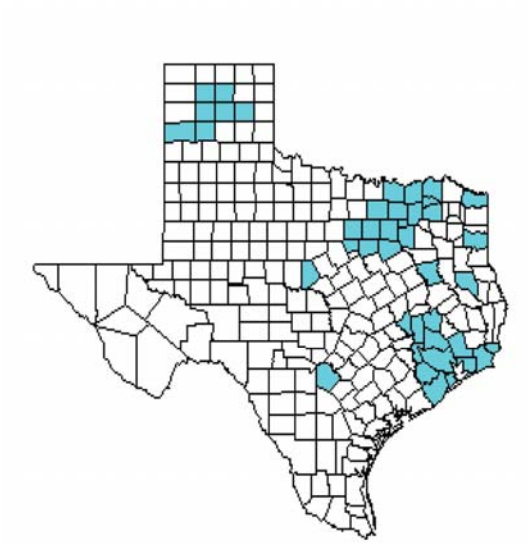
4. changes in treatment necessitated by an accident

5. treatment involving:

a. maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia
b. hormonal imbalances or other factors affecting growth or developmental disturbances
c. treatment related to temporomandibular joint disorders
d. lingually placed direct bonded appliances and arch wires (“invisible braces”)

IV. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.

Texas Service Area



Anderson	Denton	Hunt	Potter
Bexar	Ellis	Hutchinson	Randall
Bowie	Fannin	Jefferson	Rockwall
Brazoria	Fort Bend	Johnson	Tarrant
Brazos	Galveston	Kaufman	Walker
Brown	Gray	Lamar	Waller
Carson	Grayson	Liberty	
Chambers	Grimes	Montgomery	
Collin	Harris	Moore	
Dallas	Harrison	Nacogdoches	
Deaf Smith	Hood	Orange	
Delta	Hopkins	Parker	

Member Rights

During the term of the contract between us and your Organization, we guarantee that it will not decrease any benefits; increase any co-payment; or change any Principal Limitation or Exclusion. We will not cancel or fail to renew your enrollment in this Plan because of your health condition or your requirements for dental care. Your Selected General Dentist is responsible to you for all treatment and services, without interference from us.

Your dentist must follow the rules and limitations set up by us and conduct his or her professional relationship with you within the guidelines established by our Quality Management Committee, Public Policy Committee and Peer Review Committee. If our relationship with your Selected General Dentist ends, your dentist is obligated to complete any and all treatment in progress. We will arrange a transfer for you to another dentist to provide for continued coverage under the Plan. As indicated on your Enrollment Form, your signature authorizes us to obtain copies of your dental records if necessary, as permitted by law.

As a member, you have the right to…

- be treated with respect, dignity and recognition of your need for privacy and confidentiality.
- express grievances and be informed of the grievance process.
- have access and availability to dental care.
- have access to your dental records
- participate in decision-making regarding your course of treatment.
- be provided information regarding Contracting Dentists.
- be provided information regarding the services, benefits and specialty referral process provided by us.

Member Responsibilities

If you continually refuse a prescribed course of treatment, use the professional relationship for illegal means, or abuse the professional relationship, your Contracting Dentist has the right to refuse to treat you. If you receive dental care during a time you are not eligible under the Plan, you will be responsible to pay the dentist the usual and customary fee for that care. You have the responsibility to pay the co-payment associated with specific procedures you may undergo in the course of your treatment.

As a member, you have the responsibility to…

- identify yourself to your selected dental office as one of our members.
- treat the Contracting Dentist, office staff and our staff with respect and courtesy.
- keep scheduled appointments or contact the dental office twenty-four (24) hours in advance to cancel an appointment.
- cooperate with your Contracting Dentist in following a prescribed course of treatment.
- make co-payments at the time of service.
- notify us of changes in family status.
- be aware of and follow your Organization's guidelines in seeking dental care.

The following definitions are used in this Evidence of Coverage.

Co-payment
The amount paid by a member for applicable covered services that require payment by our member. Co-payments are listed in the Schedule of Benefits.

Conversion plan
A contract for dental care services to which the enrollee may be entitled after his or her eligibility for or coverage under the contract through his or her Organization has been terminated for any reason other for cause.

Dental Record
A record kept at the site of your dental care which includes diagnostic aids, intra-oral and extra-oral X-rays, written treatment records such as progress notes, dental or periodontal chartings, treatment plans, consultation reports or other written material relating to a Member's medical and dental history, diagnosis, condition, treatment and/or evaluation.

Dependent
Eligible family members of a subscriber who are enrolled in our plan.

Emergency Dental Services
Procedures administered in a dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry, to believe that immediate care is needed. Permanent restorative work is not considered part of the stabilization for emergency services.

General Dentist
A contracting dentist who agrees in writing to provide general dental services under special terms, conditions and financial reimbursement arrangements with us.

Member
An individual enrolled in our dental plan.

Organization
An employer or other entity that has contracted with us to arrange for the provision of dental care benefits.

Plan
Coverage for specified dental care services purchased by an Organization for its Members for a fixed, periodic payment made in advance of treatment. Plans often include the use of fixed co-payments and are subject to Limitations and Exclusions.

Prepayment Fee
The monthly fee paid to us by your Organization. The Prepayment Fee is not the same as a co-payment.

Selected General Dentist
A contracting dentist who has been selected by the enrollee to provide general dental services covered under our contract.

Service Area
The geographical area in which we have a panel of General Dentists and Specialty Care Dentists who have agreed to provide care to our members. We are licensed to provide dental services in the counties in the State of Texas listed on Page [19].

Specialty Care
The care provided by dentists who limit their practice to the specific specialty of endodontics, orthodontics, oral surgery, pediatric dentistry, or periodontics.

Specialty Care Dentist
A contracting dentist who agrees in writing to provide Specialty Care to our enrollees.

Subscriber
The person who represents the family unit in relation to the dental benefit program. Also known as the certificate holder or enrollee.

Termination of Benefits
A member's loss of program eligibility and disenrollment from the Plan. Reason for termination of benefits may be termination of the group contract, termination of the Subscriber's employment with the Organization or dependent status change as set forth herein.

In an effort to monitor the availability of information for members with primary language needs other than English, please indicate your language selection in the appropriate space below. Members with disabilities affecting communication can receive information through the special requirements section below by clipping out this page and returning it to:

Attention: Quality Assurance
2000 West Loop South, #2010
Houston, Texas 77027

Your primary language, if not English:_____

Please check any special requirements:

□ Interpreter □ Large Print □ Audio Tape

□ Braille □ TDYY □ Other