ASSURANT
Employee
Benefits

Group Benefits

Westwood Community School District

Dental

CERTIFICATE OF
GROUP INSURANCE

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

Policyholder: Westwood Community School District

Group Policy Number: 5,452,531

Participation Number: 0

Effective Date: For any dental expenses incurred on or after November 1, 2010.

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

President and
Chief Executive Officer

GC-90
CF

Group Dental Grievance Review Procedure

If you have received an adverse determination and wish to file a formal grievance, the procedure for such a grievance review is as follows:

1. The request for review must be in writing and made within 2 years of receipt of written notice of an adverse determination. You should attach any and all pertinent information to support your position. Send to:

   Union Security Insurance Company
   P.O. Box 2940
   Clinton, IA 52733-2940

2. A decision will be made and a written response will be sent to you within 35 calendar days from our receipt. If requested documentation from a provider has not been received by the 35th day, we will send you written notice and request an extension of no more than 10 business days to make a final determination.

3. Upon receipt of our written decision, which upholds an adverse determination, you have the right to make a written request to appear before or participate in a conference call with Union Security Insurance Company's Dental Appeals Committee.

External Review

If we have not made a determination within the required time, or we uphold an adverse determination, you do have the right to request an external review under Michigan's "Patient's Right to Independent Review Act." When requesting an external review, you must use the "Health Care-Request for External Review" form authorized by the Michigan Division of Insurance.

To obtain a publication outlining the external review process, please contact the Division of Insurance's toll free number at 877.999.6442. Forms required to request an external review may also be found at their website: www.cis.state.mi.us/ofis. The external review request form can also be obtained by contacting the Union Security Insurance Company's dental customer service line at 800.442.7742.

When filing a request for an external review, you will need to submit authorization allowing the Division of Insurance to obtain documentation from your provider. Send your request for external review to:

Michigan Division of Insurance
P.O. Box 30220
Lansing, MI 48909-7720

SCHEDULE

Eligible Persons

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

Eligible Class:

For employee insurance – Each *full-time union** employee of the *policyholder* or an *associated company,*

- who is at *active work*, and
- who is working in the United States of America,

as identified on the *policyholder's* or our records, except any temporary or seasonal worker.

*A union employee is an employee of the *policyholder* or an *associated company* employed in a position covered under a collective bargaining agreement by and between the *policyholder* or an *associated company* and a union local.

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

Associated Companies: None

Service Requirement:

On November 1, 2010: 90 days

After November 1, 2010: 90 days

Entry Date

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

Effective Date of Insurance

The dental insurance provisions of the certificate are effective for any dental expenses incurred on or after November 1, 2010 (subject to Entry Date)

Dental Insurance

Deductible Amount

Individual Deductible Amount: $25
Maximum Family
Deductible: 3 persons individually

The Individual Deductible does not apply to Class I Dental Services.

Co-Insurance Percentages

Class I Preventive Services:	80%
Class II Basic Services:	80%
Class III Major Services:	50%

Benefit Maximums:

Benefit Year Maximum:	$1,000
Overall Benefit Maximums:	
Temporomandibular joint treatment:	$1,000

Covered dental expenses are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental expenses. However, benefits will be payable based on the most current dental terminology.

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

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GENERAL DEFINITIONS

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

Active work means the expenditure of time and energy for the *policyholder* or an *associated company* at your usual place of business on a *full-time* basis.

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

Contributory means you pay part of the premium.

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

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

Doctor means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. Also, a person whom we are required to recognize as a *doctor* by the laws or regulations of the governing jurisdiction, or a person who is legally licensed to practice psychiatry, psychology or psychotherapy and whose primary work activities involve the care of patients, is a *doctor*. However, neither you nor a *family member* will be considered a *doctor*.

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

Family member means a person who is a parent, spouse, child, sibling, domestic partner, grandparent or grandchild of the *covered person*.

Full-time means working at least 35 hours per week, unless indicated otherwise in the *policy*.

Home office means our office in Kansas City, Missouri.

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

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

Noncontributory means the *policyholder* pays the premium.

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

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

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

We, us, and our mean Union Security Insurance Company.

You and your mean an eligible employee or member of the *policyholder* or an *associated company* who has become insured for a coverage.

DEFINITIONS FOR DENTAL INSURANCE

Benefit year means a calendar year beginning on January 1 of any year and ending on December 31 of that year.

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

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

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

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

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

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

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

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

Family unit means you and your *covered dependents*.

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

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

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

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

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

Other group dental expense coverage means:

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

Periodontal maintenance procedures mean recall procedures for patients who have undergone either surgical or non-surgical *treatment* for periodontal disease. The procedures include examination, periodontal evaluation and any further scaling and root planing that is *dentally necessary*.

Pre-estimate review means our review of a *dentist's* statement, including diagnostic x-rays, describing the planned *treatment* and expected charges.

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

Usual and customary (UC) charge means:

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

ELIGIBILITY AND TERMINATION PROVISIONS FOR YOU

Exception to Effective Date

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

When Your Insurance Ends

Your insurance will end on the earliest of:

- the day the *policy* ends;
- the day the *policy* is changed to end the insurance for your *eligible class*;
- the last day of the month in which you are no longer in an *eligible class*;
- the last day of the month in which you stop *active work*; however, if you renew your contract with the *policyholder* for the next school year, the *policyholder* may consider insurance to continue even though you stop *active work* during the summer recess;
- the day a required contribution was not paid; or
- the day you become covered under an optional dental plan which is sponsored by your employer, or the *policyholder*, or an *associated company* and provided through a Dental Maintenance Organization.

ELIGIBILITY AND TERMINATION PROVISIONS FOR DEPENDENTS

Eligible Dependents

Your *eligible dependents* are:

- your lawful spouse, and
- your children who are less than age 26.

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

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

Dependent Effective Date

Any *noncontributory* dependent insurance will take effect on the day the dependent becomes an *eligible dependent*, or, if later, on the Entry Date shown in the Schedule in the *policy*.

For any *contributory* dependent insurance, you must apply for dependent insurance on a form acceptable to us. You must also agree to pay your share of the premium.

- If you apply before the dependent becomes eligible, dependent insurance will take effect on the Entry Date shown in the Schedule in the *policy*.
- If you apply on the date the dependent becomes eligible, or within 31 days after that, dependent insurance will take effect on the Entry Date occurring on or after the date of your application.
- If you apply more than 31 days after the dependent becomes eligible or after dependent insurance ended because the premium was not paid, *dental insurance* will take effect on the Entry Date occurring on or after the date the request is made. However, for the first 24 months after becoming insured under the *policy*, the Late Entrant Limitation in the Special Limitations section will apply.

Exception to Dependent Effective Date

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

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

When Dependent Insurance Ends

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

- the day the *policy* ends;
- the day the *policy* is changed to end dependent insurance;

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

SPECIAL DEPENDENT INSURANCE CONTINUANCE PROVISIONS

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

Physically Handicapped or Mentally Retarded Dependent Children

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

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

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

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

SPECIAL FEDERAL CONTINUANCE PROVISIONS

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

DENTAL INSURANCE

Insurance Provided

We will pay benefits for covered dental expenses identified in the *policy* when incurred by you or a *covered dependent*, while covered under the *policy*. We will pay the co-insurance percentage shown in the Schedule after you or a *covered dependent* have satisfied any deductible required for the *benefit year*, subject to all the terms and conditions of the *policy*.

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

Deductible

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

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

The deductible will apply to you and each *covered dependent* separately each *benefit year* except as stated in the Maximum Family Deductible section.

Maximum Family Deductible

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

Benefit Year Maximum

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

Maximum Benefit for Temporomandibular Joint (TMJ) Treatment

The maximum benefit payable to you and each *covered dependent*, while insured under the *policy*, for *treatment* of temporomandibular joint dysfunction is shown in the Schedule. Any benefits applied to this maximum will also be applied to the Benefit Year Maximum for the *benefit year* in which the expense is incurred.

Covered Dental Expenses

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

- performed by or under the direction of a *dentist*, or performed by a *dental hygienist* or *denturist*;
- *dentally necessary*; and
- started and completed while you or your *covered dependent* are insured, except as otherwise provided in the Effect of Prior Plan and Extension of Benefits provisions.

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

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

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

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

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

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

We consider a temporary *treatment* to be an integral part of the final *treatment*. The sum of the fees for temporary and final *treatment* will be used to determine whether the charges are *usual and customary*.

The following is a complete list of covered dental expenses. We will not pay benefits for expenses incurred for any service not listed in the *policy*.

Class I: Preventive Dental Services

- periodic or comprehensive oral evaluation, limited to 1 time in any 6-month period;
- intraoral complete series X-rays, including bitewings and 10 to 14 periapical X-rays, or panoramic film, limited to 1 time in any 60-month period;
- bitewing X-rays (two or four films), limited to 1 time in any 12-month period;
- dental prophylaxis, limited to 1 time in any 6-month period;

- topical fluoride *treatment*, limited to:
    - 1 time in any 6-month period; and
    - *covered dependent* children less than age 14;
- sealants, limited to:
    - 1 time per tooth in any 36-month period;
    - applications made to permanent molar teeth; and
    - *covered dependent* children less than age 14;
- space maintainers, including all adjustments made within 6 months of installation, limited to *covered dependent* children less than age 19.

Class II: Basic Dental Services - (Non-Restorative)

- limited oral evaluation—problem focused, considered for payment as a separate benefit only if no other *treatment* (except X-rays) is rendered during the visit;
- intraoral periapical X-rays;
- intraoral occlusal X-rays, limited to 1 film in any 6-month period;
- extraoral X-rays, limited to 1 film in any 6-month period;
- other X-rays (except films related to orthodontic procedures or temporomandibular joint dysfunction);
- accession and examination of tissue;
- stainless steel crowns, limited to:
    - 1 time in any 36-month period;
    - teeth not restorable by an amalgam or composite filling; and
    - *covered dependent* children less than age 19;
- pulpotomy;
- root canal therapy, including all pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care, limited to 1 time on the same tooth in any 24-month period;
- apicoectomy/periradicular surgery (anterior, bicuspid, molar, each additional root), including all pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care;
- retrograde filling--per root;
- root amputation--per root;

- hemisection, including any root removal and an allowance for local anesthesia and routine post-operative care, does not include a benefit for root canal therapy;
- periodontal scaling and root planing (per quadrant), limited to 1 time per quadrant of the mouth in any 24-month period;
- *periodontal maintenance procedure* (following active treatment), limited to 1 dental prophylaxis or 1 *periodontal maintenance procedure* in any 6-month period;
- periodontal related services as listed below, limited to:
    - 1 time per quadrant of the mouth in any 36-month period with charges combined for each of these services performed in the same quadrant within the same 36-month period;
        - gingivectomy;
        - osseous surgery;
- osseous grafts;
- pedicle grafts;
- tissue grafts;
- periodontal appliances, limited to 1 appliance in any 12-month period;
- simple extraction;
- oral surgery services as listed below, including an allowance for local anesthesia and routine post-operative care;
    - surgical extractions (including extraction of wisdom teeth);
    - alveoloplasty;
    - vestibuloplasty;
    - removal of lateral exostosis—maxilla or mandible;
    - frenulectomy (frenectomy or frenotomy);
    - excision of hyperplastic tissue—per arch;
- tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus;
- extraction, erupted tooth or exposed root (elevation and/or forceps removal);
- biopsy;
- incision and drainage;

- palliative (emergency) treatment of dental pain, considered for payment as a separate benefit only if no other *treatment* (except X-rays) is rendered during the visit;

- general anesthesia and intravenous sedation, limited as follows:

    - considered for payment as a separate benefit only when medically necessary (as determined by us) and when administered in the *dentist's* office or outpatient surgical center in conjunction with complex oral surgical services which are covered under the *policy*; and

    - benefits for general anesthesia will be based on the benefit allowed for the corresponding intravenous sedation.

- consultation, including specialist consultations, limited as follows:

    - considered for payment only if billed by a *dentist* who is not providing operative *treatment*;

    - benefits will not be considered for payment if the purpose of the consultation is to describe the *dental treatment plan*;

- therapeutic drug injections.

Class II: Basic Dental Services - (Restorative)

- amalgam restorations, limited as follows:

    - multiple restorations on one surface will be considered a single filling;

    - benefits for the replacement of an existing amalgam restoration will only be considered for payment if at least:

        – 12 months have passed since the existing amalgam restoration was placed if the *covered person* or *covered dependent* is less than age 19; or

        – 36 months have passed since the existing amalgam restoration was placed if the *covered person* or *covered dependent* is age 19 or older;

    - mesial, lingual, buccal (MLB) and distal, lingual, buccal (DLB) restorations will be considered single surface restorations;

- silicate restorations;

- plastic restorations;

- composite restorations, limited as follows:

    - mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations;

    - acid etch is not covered as a separate procedure;

    - benefits for the replacement of an existing composite restoration will only be considered for payment if at least:

- 12 months have passed since the existing composite restoration was placed if the *covered person* or *covered dependent* is less than age 19; or
- 36 months have passed since the existing composite restoration was placed if the *covered person* or *covered dependent* is age 19 or older;

  - benefits for composite resin restorations on posterior teeth will be based on the benefit for the corresponding amalgam restoration;

- pin retention restorations, covered only in conjunction with an amalgam or composite restoration, pins limited to 1 time per tooth.

Class III: Major Dental Services

All benefits for the services listed below include an allowance for all temporary restorations and appliances, and 1 year follow-up care.

- inlays and onlays;
  - covered only when the tooth cannot be restored by an amalgam or composite filling;
  - covered only if more than 10 years have elapsed since last placement; and
  - limited to persons over age 16;
- porcelain restorations on anterior teeth;
- crowns;
  - covered only when the tooth cannot be restored by an amalgam or composite filling;
  - covered only if more than 10 years have elapsed since last placement; and
  - limited to persons over age 16;
- recementing inlays;
- recementing crowns;
- crown build-up, including pins and prefabricated posts;
- post and core, covered only for endodontically treated teeth requiring crowns;
- endodontic endosseous implant and endosseous implant, limited as follows:
  - benefits for the replacement of an existing implant are payable only if the existing implant is:
    - more than 10 years old; and
    - cannot be made serviceable;

- full dentures, limited as follows:
    - limited to 1 time per arch unless:
        - 10 years have elapsed since last replacement; and
        - the denture cannot be made serviceable;
    - we will not pay additional benefits for personalized dentures or overdentures or associated *treatment*;
    - we will not pay for any denture until it is accepted by the patient;
- partial dentures, including any clasps and rests and all teeth, limited as follows:
    - limited to 1 partial denture per arch unless:
        - 10 years have elapsed since last replacement (see the Denture or Bridge Replacement/Addition provision for exceptions); and
        - the partial denture cannot be made serviceable;
    - there are no benefits for precision or semi-precision attachments;
- each additional clasp and rest;
- denture adjustments, limited to:
    - 1 time in any 12 month period; and
    - adjustments made more than 12 months after the insertion of the denture;
- repairs to full or partial dentures, bridges, crowns and inlays, limited to repairs or adjustments performed more than 12 months after the initial insertion;
- relining or rebasing dentures, limited to:
    - 1 time in any 36-month period; and
    - relining or rebasing done more than 12 months after the insertion of the denture;
- tissue conditioning, limited to repairs or adjustment performed more than 12 months after the initial insertion of the denture;
- fixed bridges (including Maryland bridges), limited as follows:
    - limited to persons over age 16;
    - benefits for the replacement of an existing fixed bridge are payable only if the existing bridge:
        - is more than 10 years old (see the Denture or Bridge Replacement/Addition provision for exceptions); and

  - cannot be made serviceable;

  - a fixed bridge replacing the extracted portion of a hemisected tooth is not covered;

  - the date the bridge is cemented in the mouth will be used in determining the amount that will be applied to the Benefit Year Maximum shown in the Schedule;

- recementing bridges, limited to repairs or adjustment performed more than 12 months after the initial insertion;

- non-surgical temporomandibular joint (TMJ) *treatment* for myofascial pain syndrome, muscular, neural, or skeletal disorder, dysfunction or disease of the temporomandibular joint including *treatment* of the chewing muscles to relieve pain or muscle spasm, TMJ X-rays, and occlusal adjustments, limited as follows:

  - coverage does not include an allowance for appliances for tooth movement or guidance, electronic diagnostic modalities, occlusal analysis, or muscle testing;

  - the Overall Maximum Benefit for Temporomandibular Joint (TMJ) Treatment and the Benefit Year Maximum shown in the Schedule will apply.

Pre-estimate

If the charge for any *treatment* is expected to exceed $300, we recommend that a *dental treatment plan* be submitted to us for review before *treatment* begins. An estimate of the benefits payable will be sent to you and your *dentist*.

In estimating the amount of benefits payable, we will consider whether or not an alternate *treatment* may accomplish a professionally satisfactory result. If you or a *covered dependent* and the *dentist* agree to a more expensive *treatment* than that pre-estimated by us, we will not pay the excess amount.

The pre-estimate is not an agreement for payment of the dental expenses. The pre-estimate process lets you or a *covered dependent* know in advance approximately what portion of the expenses will be considered covered dental expenses by us.

Alternate Treatment

If an alternate *treatment* can be performed to correct a dental condition, the maximum covered dental expense we will consider for payment will be the most economical *treatment* which will, as determined by us, produce a professionally satisfactory result.

Special Limitations

Waiting Period for Timely Applicants

If you apply for *dental insurance* before or within 31 days of the date you or your dependents become eligible, you or your *covered dependents* are timely applicants. Under the Waiting Period for Timely Applicants, we will not pay benefits for the following services until you or the *covered dependents* have been continuously insured under the *policy* for the stated period of time:

Class III Dental Services – 12 months

If *treatment* for a service listed above is started during the Waiting Period, only the portion of the *treatment* rendered after the end of the Waiting Period will be considered a covered dental expense.

Late Entrant Limitation

If you apply for *dental insurance* more than 31 days after you or your dependents first become eligible, you or your *covered dependents* are late entrants. The benefits for the first 24 months of coverage for late entrants will be limited as follows:

- Until the late entrant has been insured under the *policy* for 6 months in a row, benefits will include coverage for only Class I Dental Services;

- Until the late entrant has been insured under the *policy* for 12 months in a row, benefits for the second 6 months will then include coverage for only Class I and Class II Restorative Dental Services; and

- Until the late entrant has been insured under the *policy* for 24 months in a row, benefits for the second 12 months will then include coverage for only Class I and Class II Non-Restorative and Restorative Dental Services.

If *treatment* for a service limited under this provision is started during the Late Entrant Limitation period, only the portion of the *treatment* rendered after the end of the Late Entrant Limitation period will be considered a covered dental expense.

Missing Teeth Limitation

We will not pay benefits for replacement of teeth missing on your or your *covered dependent's* effective date of insurance under the *policy* for the purpose of the initial placement of a full denture, partial denture or fixed bridge. However, expenses for the replacement of teeth missing on the effective date will be considered for payment as follows:

- The initial placement of full or partial dentures will be considered a covered dental expense if the placement includes the initial replacement of a *functioning natural tooth* extracted while you or the *covered dependent* were insured under the *policy*.

- The initial placement of a fixed bridge will be considered a covered dental expense if the placement includes the initial replacement of a *functioning natural tooth* extracted while you or the *covered dependent* were insured under the *policy*. However, the following restrictions will apply:

    - the extracted tooth will not be considered a covered dental expense if it was an abutment to an existing prosthesis;

    - benefits will only be paid for the replacement of the teeth extracted while you or the *covered dependent* were insured under the *policy*;

    - benefits will not be paid for the replacement of other teeth which were missing on your or the *covered dependent's* effective date.

Denture or Bridge Replacement/Addition

As stated in the Covered Dental Expenses section, we will not pay benefits for the replacement of a full denture, partial denture, fixed bridge or for teeth added to a partial denture unless:

- 10 years have elapsed since last replacement of the denture or bridge; and
- the denture or bridge cannot be made serviceable;

However, the following exceptions will apply:

- benefits for the replacement of an existing partial denture that is less than 10 years old will be payable if there is a *dentally necessary* extraction of an additional *functioning natural tooth*;
- benefits for the replacement of an existing fixed bridge that is less than 10 years old will be payable if:
  - there is a *dentally necessary* extraction of an additional *functioning natural tooth*; and
  - the extracted tooth was not an abutment to an existing bridge.

General Exclusions

We will not pay benefits for expenses incurred for any of the following:

1. *treatment* which:
   - is not included in the list of covered dental expenses;
   - is not *dentally necessary*;
   - is experimental in nature; or
   - does not have uniform professional endorsement;
2. appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting;
3. any *treatment* or appliance, the sole or primary purpose of which relates to:
   - the change or maintenance of vertical dimension;
   - the alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery or temporomandibular joint disorder;
   - bite registration; or
   - bite analysis;
4. replacement of a lost or stolen appliance or prosthesis;
5. educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions;
6. completion of claim forms or missed dental appointments;

7. personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders;

8. *treatment* for a jaw fracture;

9. *treatment* provided by a *dentist*, *dental hygienist*, *denturist*, or *doctor* who is:

   - an *immediate family member* or a person who ordinarily resides with you or a *covered dependent;*
   - an employee of the *policyholder*; or
   - a *policyholder*;

10. hospital or facility charges for room, supplies or emergency room expenses; or routine chest X-rays and medical exams prior to oral surgery;

11. *treatment* performed outside the United States, except for *emergency dental treatment*. The maximum benefit payable to any person during a *benefit year* for covered dental expenses related to *emergency dental treatment* performed outside the United States is $100;

12. *treatment* resulting from or in the course of your or a *covered dependent's* regular occupation for pay or profit for which you or your *covered dependent* are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify us of all such benefits;

13. *treatment* for which these conditions exist:

   - charges are payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and *treatment* is provided by a governmental agency of the United States. However, we will always reimburse any state or local medical assistance (Medicaid) agency for covered dental expenses;
   - charges are not imposed against the person or for which the person is not liable;
   - charges are reimbursable by *Medicare* Part A & Part B.* If a person at any time was entitled to enroll in the *Medicare* program (including Part B) but did not do so, his or her benefits under the *policy* will be reduced by any amount that would have been reimbursed by *Medicare*, where permitted by law;

     * However, for persons insured under *policyholders* who notify us that they employed 20 or more employees during the previous business year, this exclusion will not apply to an actively working employee and/or his or her spouse who is age 65 or older if the employee elects coverage under this plan instead of coverage under *Medicare*.

14. *treatment* provided primarily for cosmetic purposes;

15. *treatment* which may not reasonably be expected to successfully correct the person's dental condition for a period of at least 3 years, as determined by us;

16. crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;

17. *orthodontic treatment*.

Effect of Prior Plan

This provision applies only to *covered persons* and their *covered dependents* who become insured on the effective date of this policy unless otherwise specified below.

Definitions

Prior plan means the *policyholder's* plan of group dental insurance that was replaced by the *policy*.

Continuity of Coverage for You

We will provide continuity of coverage if you were covered under the *prior plan* on the day before coverage was replaced by the *policy*.

If you

- are at *active work* on the Effective Date of the *policy* and
- apply for insurance before or within 31 days of the Effective Date of the *policy*,

you will be insured under this *policy*.

If you are not at *active work* on the Effective Date of the *policy*, you will be insured by us and will be provided the benefits of the *policy* until the earliest of:

- the end of any period of continuance of the *prior plan*;
- the date a required contribution, if any, was not paid; or
- the date coverage ends, according to the provisions of the *policy*.

Continuity of Coverage for Your Dependents

We will provide continuity of coverage for your *eligible dependents*, if any, who were covered under the *prior plan* on the day before coverage was replaced by the *policy*.

If

- the dependent is not in a hospital or similar facility on the Effective Date of the *policy*, and
- you apply for dependent insurance before or within 31 days of the Effective Date of the *policy*,

the dependent will be insured under the *policy*.

If the dependent is in a hospital or similar facility on the Effective Date of the *policy*, the dependent will be insured by us and will be provided the benefits of the *policy* until the earliest of:

- the end of any period of continuance of the *prior plan*; or
- the date a required contribution, if any, was not paid; or

- the date coverage ends, according to the provisions of the *policy*.

Prior Extractions

If *treatment* is *dentally necessary* due to an extraction which occurred before the effective date of this coverage but while you or your *covered dependent* were covered under the *prior plan* and *treatment* would have been covered under the *policyholder's prior plan*, we will apply the Coverage for Treatment in Progress provision as stated below and consider expenses as follows:

- the replacement of the extracted tooth must take place within 12 months of extraction; and

- expenses must be covered dental expenses under this *policy* and the *prior plan*.

Waiting Periods and Late Entrant Limitations

If you or your covered dependents:

- were covered under the *prior plan* on the day before the *prior plan* was replaced by this *policy*;

- are eligible on the effective date of this *policy* for *dental insurance*;

and you elect *dental insurance* for yourself and your dependents under this *policy* before or within 31 days of the effective date of this *policy*, then any Waiting Period for Timely Applicants will be waived for any Class of dental services covered under the *prior plan* and this *policy*.

If you or your *covered dependents*:

- were eligible but not covered under the *prior plan* on the day before the *prior plan* was replaced by this *policy*;

- are eligible on the effective date of this *policy* for *dental insurance*; and

- you apply for *dental insurance* for yourself and your dependents under this *policy* before or within 31 days of the effective date of this *policy*, then

you and your *covered dependents* will be subject to the Late Entrant Limitation in the Special Limitations section.

Coverage for Treatment in Progress

If you or your *covered dependents* were covered under the *prior plan* on the day before the *prior plan* was replaced by this *policy*, we will pay benefits for any program of dental *treatment* already in progress on the effective date of this *policy* as stated below. However, the expenses must be covered dental expenses under this *policy* and the *prior plan*.

- Extension of Benefits under Prior Plan

  We will not pay benefits for *treatment* if:

  - the *prior plan* has an Extension of Benefits provision;
  - the *treatment* expenses were incurred under the *prior plan*; and
  - the *treatment* was completed during the extension of benefits.

- No Extension of Benefits under Prior Plan

  We will pro-rate benefits according to the percentage of *treatment* performed while insured under the *prior plan* if:

  - the *prior plan* has no extension of benefits when that plan terminates;
  - the *treatment* expenses were incurred under the *prior plan*; and
  - the *treatment* was completed while insured under this *policy*.

- Treatment Not Completed during Extension of Benefits

  We will pro-rate benefits according to the percentage of *treatment* performed while insured under the *prior plan* and during the extension if:

  - the *prior plan* has an extension of benefits;
  - the *treatment* expenses were incurred under the *prior plan*; and
  - the *treatment* was not completed during the *prior plan's* extension of benefits.

  We will consider only the percentage of *treatment* completed beyond the extension period to determine any benefits payable under this *policy*.

Deductible Credit

We will credit this *policy's* deductible amount by the amount of covered dental expenses incurred by you or a *covered dependent* in the current *benefit year* and applied to covered dental expenses under the *prior plan's* deductible. You must supply us with proof that these expenses were incurred.

Maximum Benefit Credit

All paid benefits applied to the maximum benefit amounts under the *prior plan* will also be applied to the maximum benefit amounts under this *policy*.

Extension of Benefits

If your or a *covered dependent's* insurance under the *policy* ends, we will extend benefits for any claim related to *treatment* rendered on a specific tooth that began while insured under the *policy*. We will continue to pay benefits for covered dental expenses for such *treatment* that is rendered within 30 days after the date insurance ends.

Any extension of benefits will be subject to payment of the Benefit Year Maximum, Overall Benefit Maximums and other limitations of the *policy*.

This extension will not apply if the *policyholder* ends insurance and this *policy* is replaced with another plan of group dental insurance within 30 days of the date this *policy* ends.

COORDINATION OF BENEFITS

Applicability

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

Definitions

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

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

- If you or a *covered dependent* is covered by 2 or more *plans* that compute their benefit payments on the basis of:
    - *dentally necessary, usual and customary* fees; or
    - relative-value, schedule-reimbursement methodology; or
    - other similar reimbursement methodology,

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

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

  However, if the provider has contracted with the *secondary plan* to provide:
    - the benefit or service for a specific negotiated fee; or
    - payment amount that is different than the *primary plan's* payment arrangement; and
    - if the provider's contract permits,

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

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

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

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

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

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

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

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

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

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

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

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

- Group and non-group insurance contracts, dental service prepayment coverage, or subscriber plans;
- Dental Maintenance Organization (DMO) contracts or Health Maintenance Organization (HMO) contracts;

- Closed-panel plans or other forms of group or group-type coverage, as permitted by law or regulation (whether insured or uninsured);
- Dental benefits under group or individual automobile contracts, as permitted by state law or regulation; and
- Medicare or any other federal governmental plan, as permitted by law.

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

Plan does not include any of the following:

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

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

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

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

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

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

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

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

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

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

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

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

Order of Benefit Determination

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

1. Non-Dependent or Dependent

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

   However, if

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

     then, the order of benefits between the two *plans* is reversed so that
     - the *plan* covering the person as an employee, member, policyholder, subscriber or retiree is the *secondary plan*, and
     - the other *plan* is the *primary plan*.

2. Dependent Child Covered Under More Than One Plan

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

   - For a *covered dependent* child whose parents are married or are living together, whether or not they have ever been married:
     - The *primary plan* is the *plan* of the parent whose *birthday* falls earlier in the calendar year; or
     - If both parents have the same *birthday*, the *primary plan* is the *plan* that has covered the parent the longest.

- For a *covered dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:

    - If a court decree states that one of the parents is responsible for the dependent child's dental care expenses or dental care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is the *primary plan*. This rule applies to *plan* years commencing after the *plan* is given notice of the court decree;

    - If a court decree states that both parents are responsible for the *covered dependent* child's dental care expenses or dental care coverage, benefits will be determined according to the *birthday* rule described above;

    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the *covered dependent* child, benefits will be determined according to the *birthday* rule described above; or

    - If there is no court decree allocating responsibility for the dependent child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:

        - The *plan* covering the *custodial parent*;
        - The *plan* covering the spouse of the *custodial parent*;
        - The *plan* covering the non-*custodial parent*; and then
        - The *plan* covering the spouse of the non-*custodial parent*.

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

3. Active Employee or Retired or Laid-off Employee

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

    - The *secondary plan* is the *plan* covering that same person as a retired or laid-off employee.

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

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

4. COBRA or State Continuation Coverage

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

    - COBRA, or

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

    is covered under another *plan*, then

- the *primary plan* is the *plan* covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree, and

- the *secondary plan* is the plan providing coverage under COBRA, state or other federal continuation law.

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

5. Longer or Shorter Length of Coverage

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

- The *secondary plan* is the *plan* that covered the person the shorter length of time.

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

Effect on Benefits

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

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

In addition, the *secondary plan* shall credit to its *plan* deductible any amounts it would have credited to its deductible in the absence of other dental care coverage.

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

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

Right to Receive and Release Needed Information

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

- applying the rules of *this provision*; and

- determining benefits payable under this *plan* and other *plans* covering the person claiming benefits.

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

Facility of Payment

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

Right of Recovery

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

CLAIM PROVISIONS

Payment of Benefits

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

To Whom Payable

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

Filing a Claim

1. Your *dentist* should send us notice of claim for dental *treatment*. We must have written notice of any insured loss within 30 days after it occurs, or as soon as reasonably possible. You can send the notice to our *home office*, one of our regional claims offices, or to one of our agents. We need enough information to identify you as a *covered person*. If charges for dental *treatment* are expected to be $300 or more, you can receive an estimate of benefits payable before *treatment* begins by following the procedures outlined in the Pre-estimate provision.

2. Within 15 days after the date of the notice, we will send you certain claim forms. The forms must be completed and sent to our *home office* or one of our regional claims offices. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.

3. The time limit for filing a claim is 90 days after the date of the loss.

4. To decide our liability, we may require:

    - itemized bills,
    - proof of benefits from other sources, and
    - proof that you have applied for all benefits from other sources, and that you have furnished any proof required to get them.

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

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

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

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

Physical Exam

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

Limit on Legal Action

No action at law or in equity may be brought against the *policy* until at least 60 days after you file proof of loss. No action can be brought after the applicable statute of limitations has expired, but, in any case, not after 3 years from the date of loss.

Incontestability

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

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

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

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

Overpayment

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

Subrogation Rights

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

Right to Reimbursement

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

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

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

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

GENERAL PROVISIONS

Entire Contract

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

Errors

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

Misstatements

If any information about you or the *policyholder's* plan is misstated or altered after the application is submitted, including information with respect to participation or who pays the premium and under what circumstances, the facts will determine whether insurance is in effect and in what amount. We will retroactively adjust the premium.

Certificates

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

Workers' Compensation

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

Agency

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

Fraud

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the *policy* and recovery of any amounts we have paid.

HIPAA Notice of Privacy Practices

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

I. Our Commitment

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

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

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

II. Our Use and Disclosure of Your PHI

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

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

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

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

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

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

III. Your Individual Rights

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

- **To Restrict our Use or Disclosure**. You have the right to ask us to limit our use or disclosure of your PHI. While we will consider your request, we are not legally required to agree to the additional restrictions. If we do agree to all or part of your request, we will inform you in writing. We cannot agree to limit any use and disclosure of your PHI if the use or disclosure is required by law.
- **To Access your PHI**. You have the right to view and/or copy your PHI at any time by contacting us. If you want copies of your PHI, or want your PHI in a special format, we may charge you a fee. You have a right to choose what portions of your PHI you want copied and to have prior notice of copying costs. If for some reason we deny your request for access to your PHI, we will provide a written explanation of why your request was denied and explain how you can appeal the denial.

- **To Amend your PHI**. You have the right to amend your PHI, if you believe it is incomplete or inaccurate. Your request must be in writing, with an explanation of why you feel the information should be amended. If we approve your request to amend your PHI, we will make reasonable efforts to inform others, including people you name, about the amendment to your PHI. We may deny your request for various reasons, for example, if we determine that the information is correct and complete, or if we did not create the information. If we deny your request, we will provide you a written explanation of our decision. We also will explain your rights regarding having your request and our response included with all future disclosures of your PHI.

- **To Obtain an Accounting of our Disclosures**. You have the right to receive a listing from us of all instances in which we or our business associates have disclosed your PHI for purposes other than treatment, payment, health care operations, or as authorized by you. This list will include only those disclosures made since April 14, 2003 and will only go back six years. The accounting will tell you the date we made the disclosure, the name of the person or entity to whom the disclosure was made, a description of the PHI that was disclosed, and the reason for the disclosure. There may be a charge for accounting disclosures if requested more than once a year.

- **To Request Alternative Communications**. You have the right to ask us to communicate with you about your confidential information by a different method or at another location. We will accommodate all reasonable requests.

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

IV. Who to Contact for Questions and Complaints

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

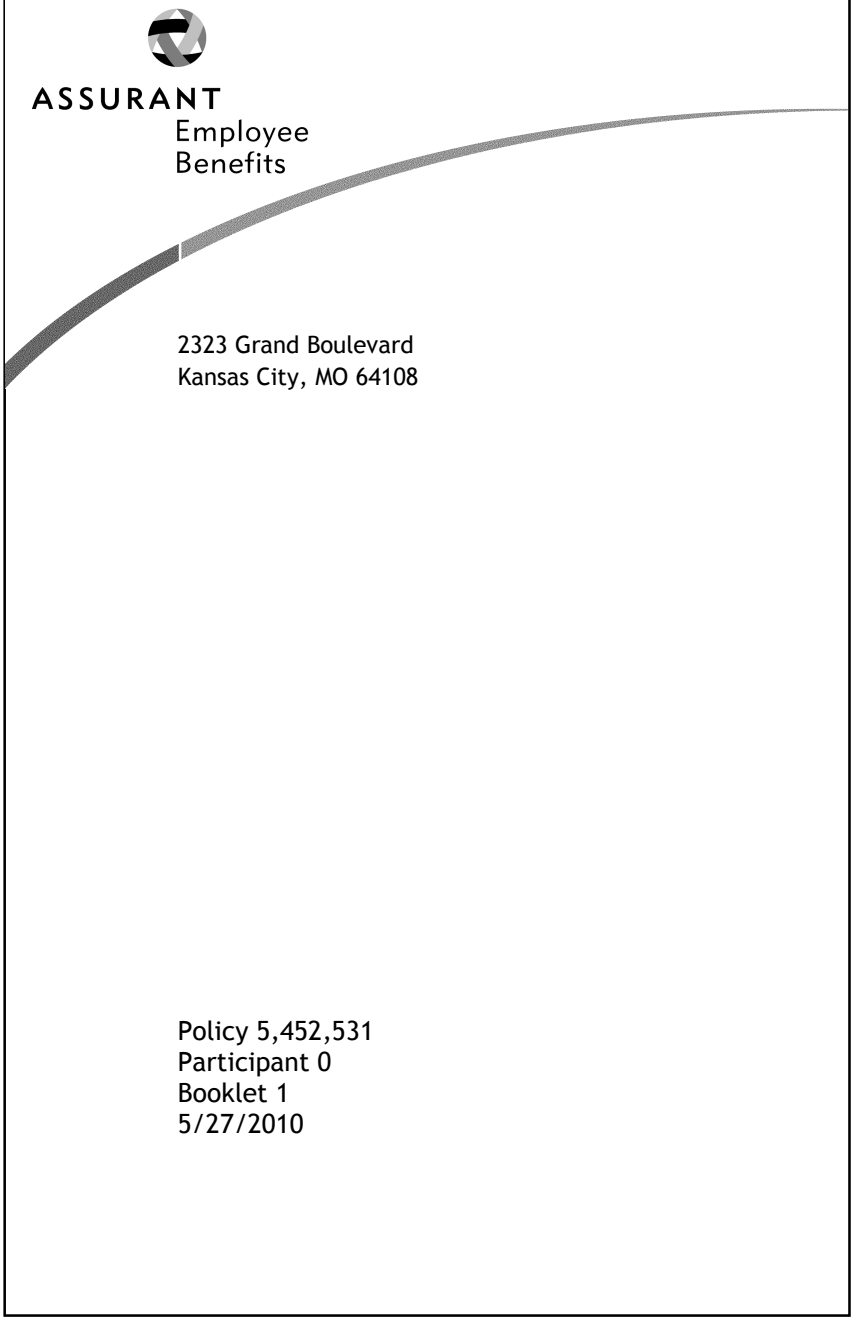
Mailing Address:	Assurant Employee Benefits Privacy Officer P.O. Box 419052 Kansas City, MO 64141-6052
Telephone:	800.733.7879
Email:	PrivacyOffice.AEB@assurant.com
Web Site:	www.assurantemployeebenefits.com

V. Organizations Covered by This Notice

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

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

*** In this notice, "we", "us", and "our" refer to Union Security Insurance Company, and the following prepaid dental companies:** DentiCare of Alabama, Inc., Union Security DentalCare of Georgia, Inc., UDC Dental California, Inc., UDC Ohio, Inc., United Dental Care of Arizona, Inc., United Dental Care of Colorado, Inc., United Dental Care of Michigan, Inc., United Dental Care of Missouri, Inc., United Dental Care of New Mexico, Inc., United Dental Care of Texas, Inc., United Dental Care of Utah, Inc., Union Security DentalCare of New Jersey, Inc.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5/27/2010