



**ASSURANT**  
Employee  
Benefits

# Group Benefits

Evergreen Manor, Inc.

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*.

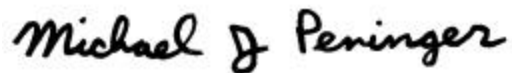
Policyholder: Evergreen Manor, Inc.

Group Policy Number: 5,346,584

Participation Number: 0

Effective Date: For any dental expenses incurred on or after April 1, 2008.

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

A handwritten signature in black ink that reads "Michael J. Peninger". The signature is written in a cursive, slightly slanted style.

Executive Vice-President

**IMPORTANT INFORMATION TO CERTIFICATE HOLDERS**

In the event that you need to contact someone about this certificate for any reason, please contact your agent. If you have additional questions, you may contact our company by mailing your questions to:

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

You may also reach Union Security by telephone at 800.442.7742.

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent or Union Security, please have your policy or participation number available.

## SCHEDULE

### Eligible Persons

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

### Eligible Class:

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

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

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

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

**Associated Companies:** None

### Service Requirement:

On April 1, 2008: 90 days

After April 1, 2008: 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

April 1, 2008 (subject to Entry Date)

### Dental Insurance

<b>Deductible Amount</b>	<b>PPO Plan</b> (In-Network Plan)	<b>Non-PPO Plan</b> (Out-of-Network Plan)
Individual Deductible Amount:	\$50	\$50
Maximum Family Deductible:	3 persons individually	3 persons individually

The Individual Deductible does not apply to Class I In-Network or Out-of-Network Dental Services.

Covered dental expenses incurred toward the deductible amount apply to both the PPO and Non-PPO Plans.

<b>Co-Insurance Percentages</b>	<b>PPO Plan</b> (In-Network Plan)	<b>Non-PPO Plan</b> (Out-of-Network Plan)
Class I Preventive Services:	100%	100%
Class II Basic Services:	90%	80%
Class III Major Services:	60%	50%

SCHEDULE (continued)

<b>Benefit Maximums:</b>	<b>PPO Plan</b> (In-Network Plan)	<b>Non-PPO Plan</b> (Out-of-Network Plan)
Benefit Year Maximum:	\$2,000	\$1,500
Overall Benefit Maximums:		
Temporomandibular joint treatment:	\$5,000	\$5,000

Amounts applied to the benefit maximums will apply to both the PPO Plan and Non-PPO Plan maximums.

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](http://www.assurantemployeebenefits.com) for details.

### Plan Changes

From March 1 through March 31 each year, a *covered person* may change his or her plan of insurance. In addition, a person may apply for insurance during this period. The effective date will be the first day of the month occurring on or after the date of the request. Any person who applies for coverage or makes a change to his or her plan of insurance during this period will not be subject to the Late Entrant Limitation in the Special Limitations section.

A *covered person* may also change his or her plan within 31 days after a change in family status event. The effective date of the change will be the first day of the month occurring on or after the date of the request.

A "change in family status" means the marriage or divorce of the *covered person*, the birth or adoption of a child of the *covered person*, the death of a spouse or child of the *covered person*, the termination of employment of the *covered person's* spouse.

Any person who applies for insurance more than 31 days after the date the person first becomes eligible or after insurance ended because the premium was not paid, will be subject to the Late Entrant Limitation in the Special Limitations section unless application is made during the annual enrollment period stated above.

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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 28 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.

## DEFINITIONS FOR DENTAL INSURANCE (continued)

*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.

*Preferred provider* means a *dentist, dental hygienist, dental office, or medical center or any dental care provider* who is a participant in our *preferred provider plan*.

*Preferred provider plan* means the dental care delivery system established by the plan manager in which *preferred providers* participate and under which we provide certain dental benefits.

*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*;
- 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 unmarried children who are less than age 25.

“Children” include any adopted children. A child will be considered adopted on the date of your legal obligation for total or partial support of the child in anticipation of the adoption. 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 do not apply within 31 days after the date the dependent becomes eligible or after dependent insurance ended because the premium was not paid, the application must be made during an annual enrollment period. Dependent insurance will take effect on the Entry Date occurring after the date of the application. However, for the first 24 months after becoming insured under the *policy*, the Late Entrant Limitation in the Special Limitations section will apply unless application is made during the annual enrollment period shown in the Schedule in the *policy*.

### 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 or adopted while dependent insurance is in effect. If dependent insurance is not in effect at the time a child is born or adopted, you must apply for dependent insurance within 60 days of the date of birth or adoption.

## ELIGIBILITY AND TERMINATION PROVISIONS FOR DEPENDENTS (continued)

### When Dependent Insurance Ends

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

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

## **SPECIAL DEPENDENT INSURANCE CONTINUANCE PROVISIONS**

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

### **Physically Handicapped or Developmentally Disabled 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 developmental disability; 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.

### Preferred Provider Plan

We will provide the benefits of the *preferred provider plan*, as shown in the Schedule, for covered expenses incurred by you or a *covered dependent* if the *treatment* is provided by a *preferred provider*. You or a *covered dependent* must be identified as being insured under the *preferred provider plan* each time *treatment* is received, to obtain the benefits of the *preferred provider plan*. We will provide the benefits of the non-preferred provider plan, as shown in the Schedule, for covered dental expenses incurred by you or a *covered dependent* if the *treatment* is provided by a dental care provider who is not a participant in the *preferred provider plan*.

### 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.

## DENTAL INSURANCE (continued)

### 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.

### Termination of a Preferred Provider's Participation under the Preferred Provider Plan

If you or a *covered dependent* incur covered dental expenses with a *preferred provider* after the provider's participation in the *preferred provider plan* has ended, benefits will not be payable for you or the *covered dependent* under the *preferred provider plan*. However, we will provide the benefits of the non-preferred provider plan shown in the Schedule.

### Termination of Our Participation under the Preferred Provider Plan

If you or a *covered dependent* incur covered dental expenses with a *preferred provider* after our participation in the *preferred provider plan* has ended, for any reason, benefits will not be payable for you or the *covered dependent* under the *preferred provider plan*. However, we will provide the benefits of the non-preferred provider plan shown in the Schedule.

### Special Benefits

Notwithstanding any other provision in the *policy*, benefits are provided for covered dental expenses related to reconstructive surgery resulting from *injury*, sickness or other diseases of the involved part or when such service is performed on a *covered dependent* child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending *doctor*.

### Covered Dental Expenses

Covered dental expenses include only the lesser of the amount agreed upon by the *preferred provider* under the *preferred provider plan*, 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:

## DENTAL INSURANCE (continued)

- 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 (four films), limited to 1 time in any 12-month period;
- dental prophylaxis, limited to 1 time in any 6-month period (frequency combined with *periodontal maintenance procedure*). Total number of combined dental prophylaxis services and *periodontal maintenance procedures* not to exceed 4 in a 12-month period;
- genetic test for susceptibility to oral diseases, limited as follows:
  - limited to 1 test per lifetime
  - limited to persons over age 18.
- 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 the occlusal surface of permanent molar teeth; and
  - *covered dependent* children less than age 14;.

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

## DENTAL INSURANCE (continued)

- 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;
- 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 (including teeth treated prior to the date the insurance takes effect under the *policy*);
- 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 related services as listed below, limited to:
  - 1 time per quadrant of the mouth in any 60-month period with charges combined for each of these services performed in the same quadrant within the same 60-month period;
    - gingivectomy;
    - osseous surgery;
    - osseous grafts;
    - pedicle grafts;
    - tissue grafts
- periodontal scaling and root planing (per quadrant), limited to 1 time per quadrant of the mouth in any 36-month period;
- *periodontal maintenance procedure*, limited to 1 *periodontal maintenance procedure* in any 3-month period (frequency combined with dental prophylaxis services). Total number of combined *periodontal maintenance procedures* and dental prophylaxis services not to exceed 4 in a 12-month period;
- localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth by report, limited to 1 application per tooth in any 12-month period;
- surgical extractions (including extraction of wisdom teeth), including an allowance for local anesthesia and routine post-operative care;
- simple extraction;
- extraction, erupted tooth or exposed root (elevation and/or forceps removal);

## DENTAL INSURANCE (continued)

- tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus;
- biopsy;
- incision and drainage;
- palliative (emergency) treatment of dental pain;

### **Class II: Basic Dental Services - (Restorative)**

- amalgam restorations, limited as follows:
  - multiple restorations on one tooth will be considered a single filling;
  - benefits for restorations on three or more surfaces will be based on the benefit allowed for the corresponding two surface restoration;
  - benefits for the replacement of an existing amalgam restoration will only be considered for payment if at least:
    - 24 months have passed since the existing amalgam restoration was placed if the *covered person* or *covered dependent* is less than age 16; or
    - 36 months have passed since the existing amalgam restoration was placed if the *covered person* or *covered dependent* is age 16 or older;
- composite restorations, limited as follows:
  - mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations;
  - benefits for the replacement of an existing composite restoration will only be considered for payment if at least:
    - 24 months have passed since the existing composite restoration was placed if the *covered person* or *covered dependent* is less than age 16; or
    - 36 months have passed since the existing composite restoration was placed if the *covered person* or *covered dependent* is age 16 or older;
  - benefits for restorations on three or more surfaces will be based on the benefit allowed for the corresponding two surface 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**

Benefits for crowns, dentures, and bridges listed below as covered dental expenses include an allowance for all temporary restorations and appliances, and 1 year follow-up care.

- space maintainers, including all adjustments made within 6 months of installation, limited to *covered dependent* children less than age 14 and to one appliance per child;

## DENTAL INSURANCE (continued)

- recementation of space maintainers, limited to recementations performed more than 12 months after the initial insertion;
- inlays and onlays, limited as follows:
  - benefits for inlays and onlays will be based on the benefit allowed for the corresponding amalgam restoration and will be subject to all limitations listed under amalgam restorations; and
  - limited to persons over age 16;
- crowns;
  - covered only when the tooth cannot be restored by an amalgam or composite filling;
  - benefits for crowns with high noble metal or noble metal will be based on the benefit allowed for the corresponding base metal;
  - covered only if more than 10 years have elapsed since last placement; and
  - limited to persons over age 16;
- recementing inlays and crowns, limited to:
  - 1 time in any 60-month period; and
  - recementations performed more than 12 months after the initial insertion;
- crown build-up, including pins and prefabricated posts;
- post and core, covered only for endodontically treated teeth requiring crowns;
- stainless steel crowns and prefabricated resin 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;
- repairs to crowns, limited to:
  - 1 time in any 60-month period; and
  - repairs performed more than 12 months after the initial insertion;
- 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;

## DENTAL INSURANCE (continued)

- 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;
- 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, 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;
- fixed 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;
  - benefits for abutment crowns with high noble metal or noble metal will be based on the benefit allowed for the corresponding base metal;

## DENTAL INSURANCE (continued)

- repairs to bridges and recementing bridges, limited to:
  - 1 time in any 60-month period; and
  - repairs, adjustments and recementations performed more than 12 months after the initial insertion;
- surgical and 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, subject to the Overall Maximum Benefit for Temporomandibular Joint (TMJ) Treatment and the Benefit Year Maximum shown in the Schedule.
- 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*;
  - benefits for general anesthesia will be based on the benefit allowed for the corresponding intravenous sedation; and
  - general anesthesia will also be considered for payment as a separate benefit when administered in the *dentist's* office if the general anesthesia is provided in conjunction with a covered dental expense and is medically necessary because the patient is under age seven or physically or developmentally disabled.

### 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

#### 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:

## DENTAL INSURANCE (continued)

- 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*;

## DENTAL INSURANCE (continued)

- 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 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. personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders;
7. *treatment* for a jaw fracture;
8. *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*;

## DENTAL INSURANCE (continued)

9. hospital or facility charges for room or supplies; or routine chest X-rays and medical exams prior to oral surgery;
10. *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;
11. *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;
12. *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*.
13. *treatment* provided primarily for cosmetic purposes, except for covered dental expenses related to a service performed on a *covered dependent* child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending *doctor*;
14. *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, except for covered dental expenses related to a service performed on a *covered dependent* child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending *doctor*;
15. crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;
16. *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*.

## DENTAL INSURANCE (continued)

### 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*.

## DENTAL INSURANCE (continued)

### 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.

### 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*.

## DENTAL INSURANCE (continued)

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

All of the benefits provided under the *policy* are subject to *this provision*.

### Definitions

*Allowable expense* means any *dentally necessary, usual and customary charge*, at least a portion of which is covered under 1 or more of the *plans* which covers the person:

- for whom claim is made, and
- on whose account payment is legally required.

When a *plan* provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be both an *allowable expense* and a benefit paid.

When benefits are reduced because the person does not comply with the provisions of a plan, the amount of the reduction will not be considered an *allowable expense*. However, any services rendered by a non-HMO/DMO provider for which the HMO/DMO denies payment will be considered an *allowable expense*.

*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*.

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

*Plan* means any plan which provides benefits or services for medical or dental care or *treatment* through:

- group or blanket insurance coverage;
- group hospital, medical, or dental service prepayment coverage, group or individual practice or other group prepayment coverage, or group-type coverage through Health Maintenance Organizations (HMOs) or Dental Maintenance Organizations (DMOs);
- a labor-management trustee plan, union welfare plan, employer or employee organization plan or any other arrangement of benefits, not available to the general public, which is based on membership in a group;
- coverage under government programs or coverage required or provided by any statute, except *Medicaid*. Benefits and services provided by Part A and Part B of *Medicare* are included. If you or a *covered dependent* are eligible for, but not covered under both Part A and Part B of *Medicare* for any reason, the benefits or services that would have been payable if you or the *covered dependent* had been covered, will be included, unless prohibited by state law or regulation; or
- *no-fault motor vehicle coverage* or a Motor Vehicle Financial Responsibility Act, unless prohibited by state law or regulation.

*Plan* does not include any of the following:

- *school accident coverage*;
- the first \$200 per day of benefits under a group or group-type hospital indemnity benefit, written on a non-expense incurred basis;

## COORDINATION OF BENEFITS (continued)

- *Medicaid*; and does not include a law or *plan* when, by law, its benefits are in excess of those of any private or other non-governmental plan; or
- *no-fault motor vehicle coverage* or a Motor Vehicle Financial Responsibility Act, which, according to its rules, determines its benefits after the benefits of *this plan* have been determined, or any optional *no-fault motor vehicle coverage*.

The term *plan* will be construed separately for each policy, contract, or other arrangement for benefits or services. It will also be construed separately for:

- that part of any policy, contract, or other arrangement which has the right to consider the benefits or services of other *plans* in determining its benefits; and
- that part which does not.

*Primary plan* means a *plan* whose benefits for health care coverage must be determined without considering the existence of any other *plan*. A *plan* is primary if:

- the *plan* has no order of benefit determination rules, or it has rules which differ from *this provision*; or
- under the order of benefit determination rules, *this plan* determines its benefits first.

*School accident coverage* means coverage for elementary, high school, or college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

*Secondary plan* is not a *primary plan*, and may consider the benefits of the *primary plan* and the benefits of any other *plan* which, under the rules of *this provision*, has its benefits determined before those of that *secondary plan*.

*This plan* means the benefits provided by the *policy*.

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

Other definitions which may apply to this Coordination of Benefits section appear in the Definitions sections of this *policy*.

### Order of Benefit Determination

The rules to establish the order of benefit determination for each *plan* are as follows:

- A *plan* which covers the claimant as an employee, member or subscriber (that is, other than as a dependent) will determine its benefits before a *plan* which covers the claimant as a dependent. However, if the claimant is also a *Medicare* beneficiary, and as the result of the rule established by Title XVIII of the Social Security Act and implementing regulations,
  - the *plan* covering the claimant as a dependent will determine its benefits before *Medicare*; and
  - *Medicare* will determine its benefits before the *plan* covering the claimant as other than a dependent (e.g. a retired employee). Then the *plan* covering the claimant as a dependent will determine its benefits before the *plan* covering the claimant as other than a dependent.

## COORDINATION OF BENEFITS (continued)

- In the event that the claimant is a dependent child whose parents are not divorced or separated, benefits for the child are determined in this order:
  - first, the *plan* which covers the claimant as a dependent child of the parent whose birthdate occurs earlier in a calendar year; and
  - second, the *plan* which covers the claimant as a dependent child of the parent whose birthdate occurs later in the calendar year.

If both parents have the same birthdate, benefits for the child are determined in this order:

- first the *plan* which covered the parent longer; and
- second, the *plan* which covered the other parent for a shorter period of time.

If the other *plan* does not contain this exact rule regarding dependents, then this rule will not apply, and the rules set forth in the other *plan* will determine the order of benefits.

- In the event that the claimant is a dependent child whose parents are divorced or separated, benefits for the child are determined in this order:
  - When the parent with custody of the child has not remarried,
    - first, the *plan* which covers the child as a dependent of the parent with custody; and
    - second, the *plan* which covers the child as a dependent of the parent without custody; or
  - When the parent with custody of the child has remarried,
    - first, the *plan* which covers the child as a dependent of the parent with custody; and
    - second, the *plan* which covers that child as a dependent of the stepparent; and
    - finally, the *plan* which covers that child as a dependent of the parent without custody; or
  - When the parents have joint custody of the child and the court does not decree which parent is responsible for the health care expenses of the child, then benefits for the child will be determined according to the birthdate rule described above.
  - If the specific terms of a court decree that one parent is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the *plan* of that parent has actual knowledge of these terms, then
    - first, the *plan* of parent with financial responsibility; and
    - second, the *plan* of the other parent.

This does not apply to any *claim period* during which any benefits are actually paid or provided before the entity has that actual knowledge.

## COORDINATION OF BENEFITS (continued)

- If the specific terms of a court decree state that both parents are responsible for the health care expenses of the child but gives physical custody of the child to a particular parent, then benefits for the child will be determined according to the birthday rule described above.
- A *plan* which covers the claimant as a laid-off or retired employee, or as a dependent of that person, will determine its benefits after a *plan* covering such claimant as an employee, other than a laid-off or retired employee, or as a dependent of that person.

If a *plan* does not have a provision regarding laid-off or retired employees, which results in each *plan* determining its benefits after the other, then this rule will not apply.

- When the claimant whose coverage is provided under a federal or state continuation law is also covered under another *plan*, benefits are determined in this order:
  - first, the *plan* which covers the claimant as an employee; and
  - second, the *plan* which covers the claimant under a continuation law.

If the other *plan* does not have a provision regarding coverage provided under continuation laws, then this rule will not apply.

- When none of the rules described above establish an Order of Benefit Determination, a *plan* which has covered the claimant longer will determine its benefits before a *plan* which has covered that claimant for a shorter period of time.

### Effect on Benefits

A *primary plan's* benefits are not reduced because of the existence of another *plan*.

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)*.

When *this plan* is a *secondary plan*, benefits payable under *this plan* will be reduced so that when they are added to the benefits payable under all other *plans*, they will not exceed the total *allowable expenses* incurred by you or the *covered dependent* during the *claim period*. Benefits payable under any other *plan* include the benefits that would have been payable had the claim for them been made. Except for Part A and Part B of *Medicare*, you or the *covered dependent* must actually be covered by the other *plans*.

We will exclude the benefits payable under any *plan* in determining the above reduction if:

- that other *plan* contains a provision which requires it to determine its benefits after the benefits of *this plan*, and
- the rules set forth in the Order of Benefit Determination require us to decide the benefits of *this plan* before the other *plan*.

When a reduction is made, each benefit that would have been payable in the absence of *this provision* will be reduced proportionately or in some other manner which we consider fair. The reduced amount will be charged against any benefit limit of *this plan* that may apply.

### Right to Receive and Release Necessary Information

A claimant will furnish any information necessary to implement *this provision*. We may release or obtain any information, with respect to the claimant, which we deem necessary. This information may be released to or received from any insurer, other organization, or person. This may be done only with the consent of the claimant.

## COORDINATION OF BENEFITS (continued)

### **Facility of Payment**

When payments which should have been made under *this plan*, by the terms of *this provision*, have been made under any other *plans*, we have the right to pay to any organization making the other payments any amounts we determine are due to satisfy the intent of *this provision*. Any amount we pay in good faith will release us from further liability for that amount.

### **Recovery of Our Payment**

If we pay more than the maximum amount required to satisfy the intent of *this provision* at that time, we have the right to recover the excess paid. We may make recovery from any persons to, or for, or with respect to whom the payments were made, or from any other insurers or organizations. This includes the reasonable cash value of any benefits provided as a service.

## CLAIM PROVISIONS

### Payment of Benefits

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

### To Whom Payable

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

### Authority

The *policyholder* delegates to us and agrees that we have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the *policy*. All determinations and interpretations made by us are conclusive and binding on all parties.

### Filing a Claim

1. Your *dentist* should send us notice of claim for dental *treatment*. You must send us notice of all other claims. 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. The *preferred provider* will send notice of all dental expenses incurred under the *preferred provider plan*.
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. The *preferred provider* will provide initial written proof of any dental expenses incurred under the *preferred provider plan*.
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.

## CLAIM PROVISIONS (continued)

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. This provision will apply only if you and your dependent are made whole.

### 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.

## CLAIM PROVISIONS (continued)

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*. This provision will apply only if you and your dependent are made whole.

## 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:	<a href="http://www.assurantemployeebenefits.com">www.assurantemployeebenefits.com</a>

#### 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.



**ASSURANT**

Employee  
Benefits

2323 Grand Boulevard  
Kansas City, MO 64108

Policy 5,346,584  
Participant 0  
Booklet 1  
3/31/2008