ASSURANT
Employee
Benefits

Group Benefits

Clinton City Schools

Dental

CERTIFICATE OF
GROUP DENTAL INSURANCE

Union Security Insurance Company certifies that the insurance stated in this Certificate became effective on the Effective Date shown in your Benefit Information form. In the event of a discrepancy between the certificate and the policy provisions, then the policy provisions will control. The *policy* is a legal contract between Union Security Insurance Company and the *policyholder*.

Union Security Insurance Company is domiciled in the State of Kansas.

This is a PPO plan.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company.

This Certificate has a Termination Provision. Please read the provision entitled "When a Person's Insurance Ends" and "When Dependent Insurance Ends" found on the page listed in the Table of Contents.

PLEASE READ YOUR CERTIFICATE CAREFULLY.

Policyholder:	Clinton City Schools
Group Policy Number:	5476376
Effective Date:	For any dental expenses incurred on or after September 1, 2015.
Type of Insurance:	Group Dental Insurance Group Dental Insurance for Dependents

READ YOUR CERTIFICATE CAREFULLY. This cover page provides only a brief outline of some of the important features of your coverage. This cover page is not the insurance contract. The *policy* sets forth, in detail, the rights and obligations of both the *policyholder* and the insurance company. IT IS THEREFORE IMPORTANT THAT YOU READ YOUR CERTIFICATE.

This Certificate replaces any and all Certificates and Certificate Endorsements, if any, previously issued to you.

President and
Chief Executive Officer

Union Security Insurance Company 2323 Grand Boulevard Kansas City Missouri 64108-2670

NOTICE TO FIDUCIARY OF OBLIGATIONS UNDER NORTH CAROLINA LAW

Under North Carolina general statute section 58-50-40, no person, employer, principal, agent, trustee, or third party administrator, who is responsible for the payment of group health or life insurance or group health plan premiums, shall: (1) cause the cancellation or nonrenewal of group health or life insurance, hospital, medical, or dental service corporation plan, multiple employer welfare arrangement, or group health plan coverages and the consequential loss of the coverages of the persons insured, by willfully failing to pay those premiums in accordance with the terms of the insurance or plan contract, and (2) willfully fail to deliver, at least 45 days before the termination of those coverages, to all persons covered by the group policy a written notice of the person's intention to stop payment of premiums. This written notice must also contain a notice to all persons covered by the group policy of their rights to health insurance conversion policies under Article 53 of Chapter 58 of the general statutes and their rights to purchase individual policies under the federal Health Insurance Portability and Accountability Act and under Article 68 of Chapter 58 of the general statutes. Violation of this law is a felony. Any person violating this law is also subject to a court order requiring the person to compensate persons insured for expenses or losses incurred as a result of the termination of the insurance.

SCHEDULE

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 *eligible dependent* of a person eligible and insured for employee insurance.

Associated Companies: None

Present Service Requirement: None

Future Service Requirement: 30 day(s)

Entry Date: An eligible person will become insured on the first of the month occurring on or after the day all eligibility requirements are met.

SCHEDULE (continued)

Dental Insurance

Deductible Amount Per Benefit Year	**Network Plan**	**Out-of-Network Plan**
Individual Deductible Amount: for Class II, III Dental Services:	$50	$50
Maximum Family Deductible:	3 persons individually	3 persons individually

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

Covered dental expenses incurred toward the deductible amount apply to both the Network and Out-of-Network Plans.

Coinsurance Percentages	**Network Plan**	**Out-of-Network Plan**
Class I Preventive Services:	100%	100%
Class II Basic Services:	80%	80%
Class III Major Services:	50%	50%
Class IV Orthodontic Services:	50%	50%

Benefit Maximums	**Network Plan**	**Out-of-Network Plan**
Benefit Year Maximum:	$750	$750
Overall Benefit Maximums: Class IV Orthodontic Services:	$1,000	$1,000

Amounts applied to the benefit maximums will apply to both the Network Plan and Out-of-Network Plan maximums.

Network and Out-of-Network Claim Payment Disclosure

A *covered person* who uses a *network provider* will receive higher levels of benefit and will not be balanced billed. The example below illustrates the savings to a *covered person* who uses a *network provider*. The example assumes an 80% coinsurance level with the deductible already met. The dollar amounts and plan features are illustrative only and may not reflect submitted fees and *allowable charges* in all areas.

Claim Example	**Network Claims**	**Out-of-Network Claims**
Dentist's Normal Charge	$800	$800
Allowable Charge	N/A	$750
Network Provider Discounted Fee	$500	N/A
Insurance Pays a Coinsurance of 80%	$400	$600
Covered Person Pays*	$100	$200

*If the *covered person* uses a *network provider* his or her cost is the reduced amount of $100. If the *covered person* uses an *out-of-network provider* he or she pays the greater amount of $200 and is also responsible for the $50 difference or the balance between the provider's normal charge and the *allowable charge*. This difference is called balanced billing.

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

Vision Plan

A *covered person* is eligible for discounted vision services. The discounted vision services are provided through a third party vendor and are not covered under an insured plan. The discounted vision services offered include discounts on eye exams, prescription glasses, and services related to prescription contact lenses. We have arranged for these third party services, however, the third party vendor is liable for the provision of these discounted vision services. We are not responsible or liable for the discounted vision services provided by or the negligence of the third party vendor.

Plan Changes

You may change your plan of insurance only during the annual enrollment period agreed upon by the *policyholder* and us, unless you have a change in family status. A plan change made during the annual enrollment period will take effect on the next following policy anniversary.

You may also apply for or change your plan within 31 days of a change in family status. The effective date of the change will be the Entry Date occurring on or after the date of the request. You may only change your plan to add or remove coverage for dependents due to a change in family status, unless the change in family status coincides with the annual enrollment period.

A "change in family status" means your marriage or divorce, the birth or adoption of your child, the requirement of a court or administrative order to include coverage for your child, the placement of a foster child, the death of your spouse or child, the termination of employment of your spouse, or any other event specified in the *policyholder's* IRC Section 125 plan, if any.

The Waiting Period for Timely Applicants provision, if any, will apply to changes made by timely applicants during an annual enrollment period and due to a change in family status.

The Late Entrant Limitation provision, if any, will apply to 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. The Late Entrant Limitation provision, if any, will not apply to your child if application is made during any annual enrollment period occurring prior to the child's third birthday.

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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 or all of the premium.

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

Covered person means an eligible employee or member of the *policyholder* or an *associated company* who has become insured for a coverage. It also includes any *covered dependent*.

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

Full-time means working at least 30 hours per week, unless indicated otherwise in the *policy*.

Home office means our office in Kansas City, Missouri.

Noncontributory means the *policyholder* pays the premium.

Policy means all:

- policy provisions;
- certificate(s) of group insurance;
- amendments;
- endorsements; and
- the *policyholder’s* application attached to the *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.

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

Allowable charge means:

- For a covered dental service rendered by a *network provider*, the *allowable charge* is based on an amount that the *network provider* has agreed to accept.

- For a covered dental service rendered by an *out-of-network provider*, the *allowable charge* is the reasonable charge. The reasonable charge is the charge made by other providers in the area for like *treatment*. Our determination of what is an *allowable charge* or reasonable charge is final for the purposes of determining benefits payable under the *policy*.

Benefit year means the period of time which begins on the *policy* anniversary date of each calendar year and ends on the day before the next following yearly *policy* anniversary date. The first benefit year begins on the *policy* effective date. The last benefit year ends on the day *dental insurance* under the *policy* ends.

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

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

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

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

- a list of the charges and dental procedures required for the *dentally necessary* care;

- any supporting pre-operative x-rays; and

- any other appropriate diagnostic materials required by us.

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

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

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

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, domestic partner, child, brother, sister, grandparent or grandchild.

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.

Network provider means a *dentist* who is a participant in the *network provider plan*.

Network provider plan means the benefits under which we provide covered dental services including *emergency dental treatment* received from a *network provider*.

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.

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.

Out-of-network provider means a *dentist* who is not a participant in the *network provider plan* at the time covered dental services are provided.

Out-of-network provider plan means the benefits which we provide for non-emergency, *dentally necessary* covered dental services received from an *out-of-network provider*.

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*.

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

SUMMARY OF GROUP DENTAL INSURANCE

This summary is intended to help understand the group insurance *policy*. It does not change any of its provisions.

Dental Insurance

We pay benefits if a *covered person* incurs covered dental expenses in excess of the deductible amount. The benefit and deductible may vary according to procedure. The *policy* explains which dental expenses receive limited or no benefits. In addition, waiting periods may apply to some procedures.

If a *covered person* has more than one dental expense plan, benefits from us may be reduced so that all benefits received are not more than the actual expenses.

NOTICE: Actual expenses for covered services may exceed the stated amounts shown in the Schedule (coinsurance percentage or copayment amount) because actual provider charges may not be used to determine Network and Out-of-Network payment obligations.

Please read
the following pages
carefully.

ELIGIBILITY AND TERMINATION PROVISIONS FOR DENTAL INSURANCE

Eligible Persons

To be eligible for insurance, a person must:

- be a member of an *eligible class*; and
- complete any Service Requirement shown in the Schedule by continuous service with the employer, the *policyholder*, or an *associated company*.

The Present Service Requirement applies to persons in an *eligible class* on the Effective Date of the *policy*. The Future Service Requirement applies to persons who become members of an *eligible class* after that.

Effective Date for an Eligible Person

Any *noncontributory* insurance will take effect on the Entry Date shown in the Schedule.

For any *contributory* insurance, a person must apply for insurance on a form acceptable to us, and agree to pay part or all of the premium.

- If a person applies before becoming eligible, insurance will take effect on the Entry Date shown in the Schedule.
- If the application is made on the date the person becomes eligible, or within 31 days after that, insurance will take effect on the Entry Date occurring on or after the date of the application.
- If application is made more than 31 days after the day the person becomes eligible or after insurance ended because the premium was not paid, then *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.

In no event will a person's insurance take effect before the *policyholder's* effective date.

Exception to Effective Date

If an eligible person is not at *active work* on the day insurance would otherwise take effect, insurance will not take effect until the person returns to *active work*. If the day insurance would normally take effect is not a regular work day for a person, insurance will take effect on that day if the person is able to do his or her regular job.

When a Person's 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 a person's *eligible class*;
- the last day of the month in which a person is no longer in an *eligible class*;
- the last day of the month in which a person stops *active work*; however, for a *covered person* who renews his or her contract with the *policyholder* for the next school year, the *policyholder* may consider insurance to continue even though the person stops *active work* during the summer recess; or
- the day a required contribution was not paid.

Re-enrollment

If a person re-enters an *eligible class* within 12 months after insurance ends, the person will not have to complete the Service Requirement again. All other provisions of the *policy* will apply as if the person were newly eligible.

DEPENDENT ELIGIBILITY AND TERMINATION PROVISIONS FOR DENTAL INSURANCE

Eligible Dependents

Your *eligible dependents* are:

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

"Children" include any newborn or adopted children, stepchildren and foster children. A child will be considered adopted on the date of placement for adoption. "Children" includes any children you are required to cover pursuant to a court or administrative order. "Children" also include any children for whom you are the legal guardian and who depend on you for support and maintenance.

An *eligible dependent* will not include any person who is a member of an *eligible class* and may not be covered under the *policy* by more than one person. However, if you and your spouse are both members of an *eligible class*, then one of you may request to be an *eligible dependent* of the other.

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.

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.
- 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. The Late Entrant Limitation will not apply to a child if application is made during any annual enrollment period occurring prior to the child's third birthday.

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. Dependent insurance for a newborn dependent child, including an adopted newborn dependent child, will automatically take effect at birth. Dependent insurance for foster children and adopted children will automatically take effect up placement in the foster home or placement for adoption. Insurance will continue for 31 days. If you want insurance to continue for a newborn, foster child or adopted child beyond 31 days, you must notify us (if you do not already have dependent child insurance or if additional premium is due) and make the required premium payment within the 31-day period. The 31-day notification period does not apply to children enrolled pursuant to a court or administrative order.

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; or
- the day a required contribution for dependent insurance was not paid.

SPECIAL INSURANCE CONTINUANCE PROVISIONS

Continuance of Insurance

The *policyholder* may elect to continue your insurance and your dependent insurance, if any, on a premium-paying basis if you are unable to perform *active work* for a reason shown below. You must remain in other respects a member of the *eligible class*. The continuance cannot be more than the maximum continuance shown below but may be a lesser time period as elected by the *policyholder*. Continuance must be based on a uniform policy, and not individual selection.

The maximum continuance for *dental insurance* is the longest applicable period described below:

- 12 months* for injury, sickness, or pregnancy;
- 3 months* for temporary lay-off (only with the *policyholder's* expectation that you will resume *active work*), leave of absence (other than a family or medical leave of absence described below), or change to part-time; or
- the end of the period the *policyholder* is required to allow* for a family or medical leave of absence under:
    - the federal Family and Medical Leave Act; or
    - any similar state law.

*after the last day of *active work*.

Any leave of absence, including a family or medical leave of absence described above, must be approved in advance in writing by the *policyholder* if the insurance is to be continued.

Dependent Continuance

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 or Mentally Handicapped 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 or mental handicap; 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 annually after that. 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.

Federal Continuance

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), a *covered person* 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 a *covered person*. We will pay the coinsurance percentage shown in the Schedule after a *covered person* has 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 a *covered person* 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 Continuity of Coverage provision, if any. No payment will be made for dental *treatment* completed after a *covered person's* insurance under the *policy* ends, except as stated in the Extension of Benefits provision.

Network Provider Plan

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

We will provide the benefits of the *out-of-network provider plan*, as shown in the Schedule, for covered dental expenses incurred by a *covered person* if the *treatment* is provided by an *out-of-network provider*. If a *covered person* needs *treatment* for a dental condition and there is not a *network provider* in your area that provides *treatment* for that specific condition, *treatment* received from an *out-of-network provider* will be considered on the same basis as if *treatment* was provided by a *network provider*.

If a *covered person* receives *emergency dental treatment* from an *out-of-network provider*, we may provide the benefits of the *network provider plan*. In order to receive the benefits of the *network provider plan* for *emergency dental treatment* received from an *out-of-network provider*, the *treatment* must be needed immediately because of an injury or sudden illness and the time required to reach a *network provider* would cause the serious deterioration of or the risk of permanent damage to a *covered person's* dental health.

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 each *covered person* 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 each *covered person* separately each *benefit year* except as stated in the Maximum Family Deductible section.

Maximum Family Deductible

The Maximum 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. Expenses incurred for Class IV: Orthodontic Dental Services will not be applied to the family deductible.

Benefit Year Maximum

The maximum benefit payable to each *covered person* during a *benefit year* is shown in the Schedule. This maximum will apply even if coverage for a *covered person* ends and starts again within the same *benefit year* or if a *covered person* has been covered both as an employee and a dependent. Benefits paid for Class IV: Orthodontic Dental Services will not be applied to the Benefit Year Maximum.

Date Started and Date Completed

If the *policy* includes any of the following listed services, we consider a dental *treatment* to be started as follows:

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

and 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.

(See Class IV: Orthodontic Dental Services for start and completion dates for *orthodontic treatment*.)

Covered Dental Expenses

Covered dental expenses include only the lesser of the discounted amount agreed upon by the *network provider* under the *network provider plan*, the *dentist's* actual charge, or the *allowable charge* for expenses incurred by a *covered person*. 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 a *covered person* is insured, except as otherwise provided in the Extension of Benefits provisions and Continuity of Coverage, if any.

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 to determine benefits.

We will only pay benefits for covered dental expenses incurred for *treatment* which 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 *allowable charges*.

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.

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

- All oral evaluations, 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
- Intraoral periapical x-rays, limited to 4 films in any 12-month period
- Intraoral occlusal x-rays, limited to 2 films in any 12-month period
- Extraoral x-rays, limited to 1 film in any 6-month period
- Bitewing x-rays (two or four films), limited to 1 time in any 12-month period
- Genetic test for susceptibility to oral diseases, limited as follows:
    - Limited to 1 test per lifetime and
    - Limited to persons over age 18
- 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 the occlusal surface of unrestored permanent molar teeth and
    - *Covered dependent* children less than age 16
- 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

<u>Diagnostic Services</u>

- Accession and examination of tissue

<u>Restorative Services (Fillings)</u>

- Amalgam restorations (fillings), 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 24 months have passed since the existing amalgam restoration was placed
- Mesial-lingual, distal-lingual, mesial-facial, and distal-facial restorations will be considered single surface restorations

- Composite restorations (fillings) on anterior teeth only, limited as follows:
  - Mesial-lingual, distal-lingual, mesial-facial, and distal-facial restorations 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
  - Benefits for composite restorations on posterior teeth will be based on the benefit allowed 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.
- Silicate restorations (fillings)

Endodontic Services

- Pulpotomy, limited to *covered dependent* children less than age 19
- Root canal therapy, including all pre-operative, operative and post-operative x-rays, canal preparation and fitting of preformed dowel or post, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care, limited to 1 time on the same tooth in any 24-month period (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 Surgical Services

- 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, limited to *treatment* when periodontal disease is present, excludes grafting after extractions

- Guided tissue regeneration
- Pedicle grafts
- Tissue grafts

Periodontal Non-surgical Services

- Periodontal scaling and root planing (per quadrant), limited to 1 time per quadrant of the mouth in any 24-month period. Benefits for prophylaxis and scaling and root planing, performed during the same appointment, will be based on the *allowable charge* for a prophylaxis. Benefits for scaling and root planing and *periodontal maintenance procedures*, performed during the same appointment, will be based on the *allowable charge* for *periodontal maintenance procedures*.
- *Periodontal maintenance procedure* (following active *treatment*), limited to 1 dental prophylaxis or 1 *periodontal maintenance procedure* in any 6-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

Oral Surgery Services

- 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
    - Orantral fistula closure

  If more than one complex surgical procedure is performed per area of the mouth, only the most inclusive surgical procedure performed will be considered a covered dental expense.
- 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 only if not performed on the same day as an extraction
- General anesthesia and intravenous sedation for the first 30 minutes and one additional 15 minute unit, limited as follows:

- Considered for payment as a separate benefit only with surgical extractions and when administered in the *dentist's* office or outpatient surgical center in conjunction with oral surgery services which are listed as covered services under the *policy*
- Benefits for general anesthesia will be based on the benefit allowed for the corresponding intravenous sedation

Other Basic Services

- Repairs to or recementing of full or partial dentures, bridges, crowns and inlays, limited to repairs or adjustments performed more than 12 months after the initial insertion
- 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
- 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 III: Major Dental Services

Inlay, Onlay, and Crown Restorations

- Inlays and onlays
  - Covered only when there is extensive decay or fracture and 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
- Crowns, including porcelain crowns on anterior teeth only (includes an allowance for all temporary restorations and appliances, and 1 year follow-up care)
  - Covered only when there is extensive decay or fracture and 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
- Labial veneers (only for anterior teeth)
  - Covered only if more than 10 years have elapsed since last placement and
  - Limited to persons over age 16
- Crown build-up, including pins and prefabricated posts
- Post and core, covered only for endodontically treated teeth requiring crowns

- 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

Full and Partial Dentures (Removable)

- Full dentures (includes an allowance for all temporary restorations and appliances, and 1 year follow-up care), 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*
- Partial dentures, including any clasps and rests and teeth, (includes an allowance for all temporary restorations and appliances, and 1 year follow-up care), limited as follows:
    - Limited to 1 partial denture per arch unless
        - 10 years have elapsed since last replacement, unless there is a *dentally necessary* extraction of an additional *functioning natural tooth* 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
- 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 performed more than 12 months after the initial insertion of the denture

Fixed Partial Dentures (Bridges)

- Fixed bridges, limited as follows (includes an allowance for all temporary restorations and appliances, and 1 year follow-up care)
    - 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 and

  - cannot be made serviceable

  unless there is a *dentally necessary* extraction of an additional *functioning natural tooth* and the extracted tooth was not an abutment to an existing bridge

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

Other Major Services

- Occlusal guards, limited for the *treatment* of bruxism (grinding of teeth)

Class IV: Orthodontic Dental Services

- Diagnostic x-rays, limited to x-rays for orthodontic purposes
- Diagnostic casts, limited to casts made for orthodontic purposes
- Surgical exposure of an impacted tooth, limited to services performed for orthodontic purposes
- Orthodontic appliances for tooth guidance and
- Fixed or removable appliances to correct harmful habits

Benefits for *orthodontic treatment* will only be provided to *covered dependent* children.

Benefits for *orthodontic treatment* are not payable for expenses incurred for retention of orthodontic relationships. Benefits for *orthodontic treatment* are payable only for active *orthodontic treatment* for the services listed above.

We will pay benefits for the orthodontic services listed above when the date started for the orthodontic service occurs while the person is insured under this *policy*. No payment will be made for *orthodontic treatment* if the appliances or bands are inserted prior to becoming insured, except as provided in the Continuity of Coverage provision. We consider *orthodontic treatment* to be started on the date the bands or appliances are inserted. Any other *orthodontic treatment* that can be completed on the same day it is rendered is considered to be started and completed on the date the *orthodontic treatment* is rendered.

We will pay the coinsurance percentage amount shown in the Schedule. The maximum benefit payable to each person, while insured under the *policy*, for orthodontic services is shown in the Schedule. The maximum benefit will apply even if coverage is interrupted. Benefits paid for orthodontic services will not be applied to the Benefit Year Maximum shown in the Schedule.

We will make a payment for covered orthodontic services related to the initial *orthodontic treatment* which consists of diagnosis, evaluation, pre-care and insertion of bands or appliances. After the payment for the initial *orthodontic treatment*, benefits for covered orthodontic services will be paid in equal quarterly installments over the course of the remaining *orthodontic treatment*. The benefit payment schedule for the initial *orthodontic treatment* and quarterly installments will be determined as follows:

- We will determine the lesser of the *allowable charge* and the orthodontist's fee and multiply that amount by the co-insurance rate shown in the Schedule.
- The lesser of the amount from the bullet above or the Overall Benefit Maximum for orthodontic services shown in the Schedule will be the maximum benefit payable. An initial amount of 25% of the maximum benefit payable will be paid for the initial

orthodontic treatment. This amount will be payable as of the date appliances or bands are inserted.

- The remaining 75% of the maximum benefit payable will be divided by the number of quarters that *orthodontic treatment* will continue to determine the amount which will be payable for each subsequent quarter of *orthodontic treatment*. The subsequent quarterly payments will be made only if the person remains insured under this *policy* and provides proof to us that *orthodontic treatment* continues. If *orthodontic treatment* continues after the maximum benefit payable has been paid, no further benefits will be paid.

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 the *covered person* and the *dentist*.

In estimating the amount of benefits payable, we will consider whether or not an alternate *treatment* may accomplish a professionally satisfactory result. If a *covered person* 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 a *covered person* 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 produce a professionally satisfactory result. We will not provide a full payment, a partial payment, or an alternate *treatment* payment for any service that is not a covered dental expense.

Special Limitations

Late Entrant Limitation

If you apply for *dental insurance* more than 31 days after a *covered person* first becomes eligible, the person is a late entrant. The benefits for the first 24 months of coverage for late entrants will be limited as follows:

Time Insured Continuously Under the Policy	Benefits Provided for Only These Services
Less than 6 months	Class I Dental Services
At least 6 months but less than 12 months	Class I & Class II Restorative Services
At least 12 months but less than 24 months	Class I & all Class II Dental Services

We will not pay for any *treatment* that is started or completed during the late entrant limitation period.

This provision does not apply to any *covered dependent* child after you became insured under the *policy* if we did not receive notification of the child's birth, adoption or placement in your home and no additional premium is required.

General Exclusions

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

- *Treatment* or an appliance which
  - Is not included in the list of covered dental expenses

- Is not *dentally necessary*
- Is experimental in nature
- Is temporary in nature
- Does not have uniform professional endorsement

- *Treatment* related to procedures that are:
  - Part of a service but are not reported as separate services
  - Reported in a *treatment* sequence that is not appropriate
  - Misreported or that represent a procedure other than the one reported
- Appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting
- 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
  - Bite registration
  - Bite analysis
  - Attrition or abrasion
- Replacement of a lost or stolen appliance or prosthesis
- Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions
- Completion of claim forms or missed dental appointments
- Personal supplies or equipment, including but not limited to water piks, toothbrushes, floss holders, or athletic mouthguards
- Administration of nitrous oxide or any other agent to control anxiety
- *Treatment* for a jaw fracture
- *Treatment* provided by a *dentist*, *dental hygienist*, or *denturist* who is
  - An *immediate family member* or a person who ordinarily resides with a *covered person*
  - An employee of the *policyholder*
  - A *policyholder*
- Hospital or facility charges for room, supplies or emergency room expenses or routine chest x-rays and medical exams prior to oral surgery

- *Treatment* provided primarily for cosmetic purposes, except for *treatment* primarily for cosmetic purposes which is related to congenital defects or anomalies of a *covered dependent* child insured under the *policy* at the time of birth. Upon placement in your home, adopted and foster children who are *covered dependents* will become eligible for coverage of congenital defects or anomalies on the same basis as newborn children

- *Treatment* which may not reasonably be expected to successfully correct the person's dental condition for a period of at least 3 years

- Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which do not have extensive decay or fracture and can be restored with an amalgam or composite resin filling

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

- *Treatment* for implants, implant abutments, implant supported prosthetics (crown, fixed partial denture, dentures) or any other services related to the care and *treatment* of the implant

- *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.

- Services or supplies for the *treatment* of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to the final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act

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

- *Treatment* for which a *covered person* does not have to pay, except when payment of such benefits is required by law and only to the extent required by law

Extension of Benefits

If a *covered person's* insurance under the *policy* ends, we will extend benefits for any claim related to non-orthodontic dental *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.

If a *covered person's* insurance under the *policy* ends, benefits for *orthodontic treatment* will be paid only for covered dental expenses incurred while insured under the *policy* and only until the end of the quarter in which 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 the *policy* is replaced with another plan of group dental insurance within 30 days of the date the *policy* ends.

CONTINUITY OF COVERAGE

Definitions

Prior plan means the *policyholder's* plan of group dental insurance, if any, under which you were insured on the day before the Effective Date of the *policy.*

Continuity of Coverage for You

If the *policy* replaces the *prior plan*, 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

If the *policy* replaces the *prior plan*, 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 a *covered person* was 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 a *covered person*:

- was covered under the *prior plan* on the day before the *prior plan* was replaced by this *policy*;
- is 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 a *covered person*:

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

a *covered person* will be subject to the Late Entrant Limitation in the Special Limitations section.

Coverage for Treatment in Progress

If a *covered person* was 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 a *covered person* 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*.

If a *covered person* had orthodontic coverage under the *policyholder's prior plan* and you have orthodontic coverage under this *policy*, we will not pay benefits for orthodontic expenses unless:

- you submit proof that the Overall Benefit Maximum for Class IV Orthodontic Services for this *policy* was not exceeded under the *prior plan*;
- *orthodontic treatment* was started and bands or appliances were inserted while insured under the *prior plan*;
- payment was made for *orthodontic treatment* under the *prior plan*, and
- *orthodontic treatment* is continued while a *covered person* is insured under this *policy*.

If you submit the required proof, the maximum benefit for *orthodontic treatment* will be the lesser of this *policy's* Overall Benefit Maximum for Class IV Orthodontic Services or the *prior plan's* maximum benefit. The maximum benefit payable under this *policy* will be reduced by the amount paid or payable under the *prior plan*.

COORDINATION OF BENEFITS

Applicability

The Coordination of Benefits (COB) provision applies when a *covered person* 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 necessary, reasonable, and customary dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by one or more *plans* covering the person for whom the claim is made. When a *plan* provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an *allowable expense* and a benefit paid. Total benefits paid must be equal to 100 percent of necessary dental expenses covered by both plans. 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 a *covered person* is not an *allowable expense*.

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

- If a *covered person* 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 a *covered person* 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 a *covered person* 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 *secondary plan* to determine its benefits.

- The amount of any benefit reduction by the *primary plan* because a *covered person* 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 a *covered person* 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 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 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;
- Blanket coverage;
- Franchise individual coverage;
- Automobile coverage;
- Homeowner 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 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 a *covered person* 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 a *covered person* 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

   - a *covered person* 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 or member);

     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 not 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 a *covered person* 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 a *covered person* 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 a *covered person* is covered by more than one dental benefit *plan*, the person should file all 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 a *covered person*. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

CLAIM PROVISIONS FOR DENTAL INSURANCE

Payment of Benefits

We will pay benefits immediately upon receipt of all the required proof of covered loss.

To Whom Payable

If benefits have been assigned to the providers, we will pay dental benefits directly to the providers of dental services for *treatment* of a *covered person*. We will pay dental benefits to you, if benefits have not been assigned to the providers. A *covered person* does not have to assign benefits to a *network provider*. We will pay dental benefits directly to the *network provider*. 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.

Notice of Claim

The *covered person* or the *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. Notice can be sent to our *home office*, one of our regional claims offices, or to one of our agents. We need enough information to identify the *covered person*. The *network provider* will send notice of all dental expenses incurred under the *network provider plan*. The dental expenses incurred under the *out-of-network provider plan* may be submitted by the *covered person* or the *out-of-network provider*.

Claim Forms

Within 15 days after the date of the notice, we will send the *covered person* certain claim forms. The forms must be completed and sent to our *home office* or one of our regional claims offices. If the claim forms are not received within 15 days, we will accept a written description of the exact nature and extent of the loss. The *network provider* will provide initial written proof of any dental expenses incurred under the *network provider plan*.

Proofs of Loss

The following requirements will apply to claims submitted by the *covered person*, the *network provider* and *out-of-network provider*. The time limit for filing a claim is 180 days after the date of loss. Failure to submit a claim within this time period, however, shall not invalidate or reduce the claim if it was not reasonably possible to submit the claim within such time period, provided the claim was submitted as soon as reasonably possible and in no event, except in absence of legal capacity, later than one year from the required date of 180 days after the date of service.

To decide our liability, we may require:

- itemized bills,
- proof of benefits from other sources, and
- proof that the *covered person* has applied for all benefits from other sources, and that the *covered person* has 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 the *covered person* to authorize the sources of medical and dental services to release medical information. If the *covered person* does 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 the claim if the *covered person* gives us proof as soon as reasonably possible.

Limit on Legal Action

No action at law or in equity may be brought against the *policy* until at least 60 days after the *covered person* files proof of loss. No action can be brought after the statute of limitations has expired in the *covered person's* state, but, in any case, not after 3 years from the time written proof of loss is required.

Review Procedure

If a claim is denied, in whole or in part, the *covered person* may request that we review the denial. A written request for review must be made within 90 days after notice of denial has been received. A court may not review a denial until our internal review has been completed. It is important that a request for a review is made on a timely basis.

A *covered person* has the right to see, upon request and free of charge, copies of all documents, records, and other information relevant to a claim for benefits. In connection with a request for a review of a denial, the *covered person* may submit written comments, documents, records and other information relating to a claim for benefits.

We will review a claim after receiving the request and any accompanying documentation, and send notice of our review decision within 21 days after we receive the request. We will state the reasons for our review decision and refer to the relevant provisions of the *policy*. We will also advise the *covered person* of any further internal review procedures, if applicable.

Incontestability

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

In the absence of fraud, 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*.

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

No claim for loss starting 12 or more months 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 no payment, or a lesser amount, should have been paid, we will be entitled to a refund from the provider or the *covered person* of any amounts that should not have been paid. The recovery of overpayments or offsetting of future payments must be made within the two years after the date of the original claim payment unless we have reasonable belief of fraud or other intentional misconduct by the health care provider or health care facility or its agents, or the claim involves a provider or facility receiving payment for the same service from a government payor.

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.

This Notice applies to our HIPAA covered healthcare plans, including dental, vision, cancer only, hospital indemnity, and critical illness.

I. Our Commitment

Union Security Insurance Company, Union Security Life Insurance Company of New York, and its affiliated prepaid 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 healthcare operations without asking your permission. For instance, we may disclose information to a healthcare provider to assist the provider in properly treating you or a dependent (Treatment). We may disclose certain information to the healthcare 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 healthcare operations include:

- Underwriting our risk and determining rates and premiums for your healthcare plan;
- Determining your eligibility for benefits;
- Reviewing the competence and qualifications of healthcare providers;
- Conducting or arranging for 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 healthcare 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, including uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute the sale of protected health information. We are prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes. 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 the past six years which we or our business associates have disclosed your PHI

for purposes other than treatment, payment, health care operations, or as authorized by you. 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 Be Notified of a Breach:** You will be notified in the event that unsecured protected health information is compromised.

- **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 web site 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/. 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

For New York business:

Mailing Address: **Union Security Life Insurance Company of New York**
Privacy Officer
Administered by:
Assurant Employee Benefits
P.O. Box 419052
Kansas City, MO 64141-6052
Telephone: 888.901.6377
Email: CR4U@assurant.com

V. Organizations Covered by This Notice

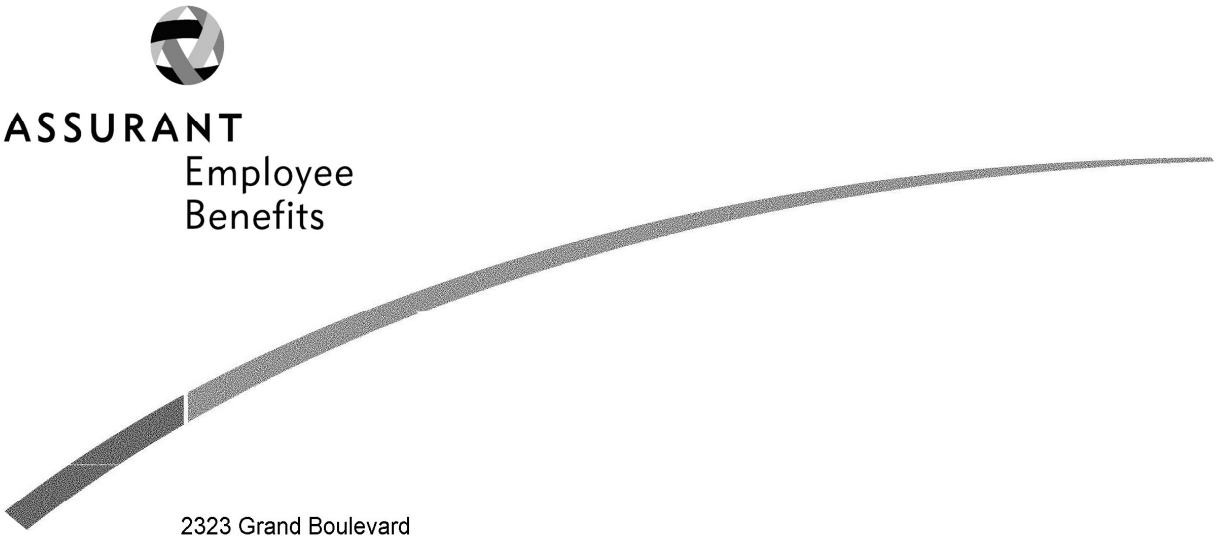
This notice applies to the privacy practices of the organizations referenced below. These organizations may share your PHI with each other as needed for payment activities or health care operations relating to the healthcare plans that we provide.

VI. Effective Date of This Notice: April 14, 2003.
Revised: July 11, 2014

*** In this notice, "we," "us," and "our" refer to Union Security Insurance Company, Union Security Life Insurance Company of New York 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 is the brand name for insurance products underwritten by Union Security Insurance Company and for prepaid products provided by affiliated prepaid dental companies. Assurant Employee Benefits is the brand name for Group Hospital Confinement Indemnity “Gap” or Supplemental Medical Expense “Gap” insurance underwritten by Fidelity Security Life Insurance Company, Kansas City, MO 64111. In New York, Assurant Employee Benefits is the brand name for certain insurance products underwritten by and prepaid products provided by Union Security Life Insurance Company of New York, which is licensed solely in New York, has its principal place of business in Fayetteville, NY, and is solely responsible for the financial obligations of its policies.



2323 Grand Boulevard
Kansas City, MO 64108

Policy 5476376
Participant 0
Booklet 1
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