Individual Dental Insurance Policy

Plan Name: Health Net of CA Med Supp P&D Plus Buy Up

Plan Code: BT

Offered and Underwritten by

Unimerica Life Insurance Company

Individual Dental Insurance Policy

Unimerica Life Insurance Company

10701 W. Research Drive

Milwaukee, Wisconsin 53226

800-357-1371

This Policy sets forth your rights and obligations as a Policyholder. It is important that you READ YOUR POLICY CAREFULLY and familiarize yourself with its terms and conditions. Unimerica Life Insurance Company ("Company") agrees to provide Coverage for Dental Services to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. The Policy is issued on the basis of the Policyholder's application and payment of the required Premium. The Policyholder's application is made a part of the Policy.

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

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

10-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

Please read this Policy. If you are not satisfied, you may notify us within 10 days after you received it. Any Premium paid will be refunded, less claims paid. This Policy will then be void from its start.

Check the attached application. If it is not complete or has an error, please let us know. An incorrect application may cause your Policy to be voided, or a claim to be reduced or denied.

This Policy is signed for us as of the effective date as shown in Exhibit 1 to the Policy.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at the number on the back of your ID card, or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

Issued By:

UNIMERICA LIFE INSURANCE COMPANY

Diane D. Souza, Chief Executive Officer

Introduction to Your Policy

You and any of your Enrolled Dependents, are eligible for Coverage under the Policy if the required Premiums have been paid. Coverage is subject to the terms, conditions, exclusions, and limitations of the Policy.

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

How To Use This Policy

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

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

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

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

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

Network and Non-Network Benefits

Network Benefits - These benefits apply when you choose to obtain Dental Services from a Network Dentist. *Section 9: Procedures for Obtaining Benefits* describes the procedures for obtaining Covered Dental Services as Network Benefits. Unless otherwise noted in the *Schedule of Covered Dental Services* or *Section 10: Covered Dental Services*, Network Benefits are subject to payment of a Deductible and generally require you to pay less to the provider than Non-Network Benefits. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dentist an amount for a Covered Dental Service in excess of the contracted fee.

Non-Network Benefits - These benefits apply when you decide to obtain Dental Services from Non-Network Dentists. *Section 9: Procedures for Obtaining Benefits* describes the procedures for obtaining Covered Dental Services as Non-Network Benefits. Unless otherwise noted in the *Schedule of Covered Dental Services* or *Section 10: Covered Dental Services*, Non-Network Benefits are subject to a Deductible and generally require you to pay more than Network Benefits. Non-Network Benefits are determined based on the contracted fee for similarly situated Network Dentists for each Covered Dental Service. The actual charge made by a Non-Network Dentist for a Covered Dental Service may exceed the contracted fee. As a result, you may be required to pay a Non-Network Dentist an amount for a Covered Dental Service in excess of the contracted fee. In addition, when you obtain Covered Dental Services from Non-Network Dentists, you must file a claim with the Company to be reimbursed for Eligible Expenses.

The information in *Section 1: Definitions* through *Section 8: Refund of Expenses* applies to both levels of Coverage. *Section 9: Procedures for Obtaining Benefits*, the *Schedule of Covered Dental Services* and *Section 10: Covered Dental Services* explain the procedures you must follow to obtain Coverage for Network Benefits and Non-Network Benefits. The *Schedule of Covered Dental Services* or *Section 10: Covered Dental Services* describe which Dental Services are Covered. Unless otherwise specified, the exclusions and limitations that appear in *Section 11: General Exclusions* apply to both levels of benefits. The *Schedule of Covered Dental Services* or *Section 10: Covered Dental Services* describe what Copayments are required, if any, and to what extent any limitations apply.

Dental Services Covered Under the Policy

In order for Dental Services to be Covered as Network Benefits, you must obtain all Dental Services directly from or through a Network Dentist.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling the Company and/or provider. If necessary, the Company can provide assistance in referring you to Network Dentists. If you use a provider that is not a participating provider, you will be required to pay the entire bill for the services you received.

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

The Company will interpret the benefits Covered under the Policy and the other terms, conditions, limitations and exclusions set out in the Policy and make factual determinations related to the Policy and its benefits. The Company may, from time to time, delegate authority to other persons or entities providing services in regard to the Policy.

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

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

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

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

Important Note About Services

The Company does not provide Dental Services or practice dentistry. Rather, the Company arranges for providers of Dental Services to participate in a Network. Network Dentists are independent practitioners and are not employees of the Company. The Company, therefore, makes payment to Network Dentists through various types of contractual arrangements. These arrangements may include financial incentives to promote the delivery of dental care in a cost efficient and effective manner. Such financial incentives are not intended to impact your access to Necessary Dental Services.

The payment methods used to pay any specific Network Dentist vary. The method may also change at the time providers renew their contracts with the Company. If you have questions about whether there are any financial incentives in your Network Dentist's contract with the Company, please contact the Company at the telephone number on your ID card. The Company can advise you whether your Network Dentist is paid by any financial incentive, however, the specific terms, including rates of payment, are confidential and cannot be disclosed.

The Dentist-patient relationship is between you and your Dentist. This means that:

- You are responsible for choosing your own Dentist.
- You must decide if any Dentist treating you is right for you. This includes Network Dentists who you choose or providers to whom you have been referred.
- You must decide with your Dentist what care you should receive.
- Your Dentist is solely responsible for the quality of the care you receive.

The Company makes decisions about eligibility and if a benefit is a Covered benefit under the Policy. These decisions are administrative decisions. The Company is not liable for any act or omission of a provider of Dental Services.

Identification ("ID") Card

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

Contact the Company

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

Dental Insurance Policy Table of Contents

Section 1: Definitions

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

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

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

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

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

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

Covered Services or **Covered Dental Services** - dental care services for which the plan or insurer is obligated to pay pursuant to an enrollee's plan contract or insured's policy or for which the plan or insurer would be obligated to pay pursuant to an enrollee's plan contract or insured's policy but for the application of contractual limitations, such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, or alternative benefit payments.

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

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

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

Dependent - (1.) the Policyholder's legal spouse. All references to the spouse of a Policyholder shall include a Domestic Partner or (2.) a dependent child of the Policyholder or the Policyholder's spouse (including a natural child, stepchild, a legally adopted child, a child placed for adoption, or a child for whom legal guardianship has been awarded to the Policyholder or the Policyholder's spouse). The term child also includes a grandchild of either the Policyholder or the Policyholder's spouse. To be eligible for coverage under the Policy, a Dependent must reside within the United States. The definition of Dependent is subject to the following conditions and limitations:

A. The term Dependent will not include any dependent child 26 years of age or older, except as stated in *Section 3: Termination of Coverage, sub-section 3.3: Extended Coverage for Handicapped Children*.

The Policyholder agrees to reimburse the Company for any Dental Services provided to the child at a time when the child did not satisfy these conditions.

Domestic Partner - A Registered Domestic Partner.

Domestic Partnership - A Registered Domestic Partnership.

Eligible Person - a person who meets the eligibility requirements specified in both the application and the Policy.

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

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

Experimental, Investigational or Unproven Services - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, is determined to be:

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

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

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

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

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

Maximum Benefit – the maximum amount paid for Covered Dental Services during a calendar year for a Covered Person under the Policy or any Policy, issued by the Company to the Policyholder, that replaces the Policy. The Maximum Benefit is stated in *Section 10: Covered Dental Services*.

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

A. Consistent in type, frequency and duration of treatment with guidelines of national clinical, research, or health care coverage organizations; and

B. Consistent with the diagnosis of the condition; and

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

D. Demonstrated through scientifically researched dental data and criteria to be safe and effective for treating or diagnosing the condition or sickness for which their use is proposed.

Network - a group of Dentists who are subject to a participation agreement in effect with the Company, directly or through another entity, to provide Dental Services to Covered Persons. The participation status of providers will change from time to time.

Network Benefits - benefits available for Covered Dental Services when provided by a Dentist who is a Network Dentist.

Non-Network Benefits - coverage available for Dental Services obtained from Non-Network Dentists.

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

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

Policyholder - means the person to whom the Policy is issued.

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

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

Registered Domestic Partner - a person of the opposite or same sex with whom the Policyholder has established a Registered Domestic Partnership, as defined by California Family Code, Section 297-297.5 and registered pursuant to California Family Code, Section 298.

Registered Domestic Partnership - a relationship between the Policyholder and one other person of the opposite or same sex, as defined by California Family Code, Section 297-297.5 and registered pursuant to California Family Code, Section 298.

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

Section 2: Effective Date of Coverage

Section 2.1 Application and Effective Date of Insurance

Application

You must complete an application that we provide.

Effective Date

We have the right to accept or decline your application based upon information provided. Your insurance will become effective at 12:01 a.m. Central Standard Time on the effective date.

Section 2.2 Dependent Eligibility and Application

Eligible Dependents

If you apply for coverage, each of your eligible Dependents may also apply. A Dependent is eligible when he or she satisfies the Policy definition of Dependent.

No Dependent is eligible while on full-time active duty with a United States military service, military reserves, or National Guard, except when the duty is for less than 31 consecutive days.

We have the right to accept or decline your Dependent's application based on information on the completed application.

Dependent Eligibility Date to Apply

Your Dependent must satisfy the Policy definition of Dependent.

Your Dependent’s eligibility date to apply is:

1. Your application date if you enroll the Dependent on the date when you enroll for insurance;
2. The date when you first acquire the Dependent if at a later date. You may acquire a new Dependent because of:
    a. Marriage;
    b. Birth;
    c. Adoption or placement for adoption;
    d. Legal responsibility for a foster child; or
    e. Legal guardianship for a child.

Initial Dependent Application Period

An application that we provide must be completed. Your spouse and Dependent child(ren) over age 18 must also complete and sign the completed application if you are enrolling your spouse and Dependent child(ren) over age 18 for insurance. We must receive the completed application within 31 days from the Dependent eligibility date.

We have the right to accept or decline your Dependent's application based upon information provided. Application will not be denied for a newborn or adopted child if application is made within 31 days from the Dependent's eligibility date.

Late Enrollee for Dependent Insurance

If we receive the application after the initial Dependent application period, we have the right to decline the application based on the Dependent's application.

Dependent Effective Date

A Dependent's effective date for insurance is shown in the Exhibit 1 to the Policy.

If you enroll the Dependent during the initial application period and we accept the Dependent for coverage, the Dependent's effective date will be the same as your effective date.

If you enroll the Dependent within 31 days from the Dependent's eligibility date, the Dependent's effective date will be:

1. In the case of marriage, the date of marriage;
2. In the case of a Dependent's birth, the date of such birth;
3. In the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption; or
4. In the case of a foster child, the date the foster child is placed in your home.

If you enroll the Dependent as a late enrollee after the Dependent's original application period and we accept the Dependent for coverage, the Dependent will become effective on the date we specify.

Your Dependent's insurance will become effective at 12:01 a.m. Central Standard Time on the effective date of coverage.

Section 3: Termination of Coverage

Section 3.1 Plan Renewals

Your Plan renews on each monthly Premium due date, subject to:

1. The Termination of Insurance provisions in the Policy; and
2. Our right to change Premiums as described in the Premium Changes section in the Policy.

Section 3.2 Termination of Insurance

Termination of Insurance for You and Your Dependents

Insurance for you and your Dependents terminates when the first of the following events occurs:

1. The date the Policy is terminated by the Policyholder or by us;
2. The date you fail to pay us the required Premiums and/or fees by the due date, subject to the Grace Period provision;
3. The date you perform an act or practice that is fraudulent, or made an intentional misrepresentation of a material fact under the terms of insurance under the Plan;
4. The date you move to a state where we are not authorized to do business or are not actively marketing;
5. The date we discontinue offering and renewing all individual dental coverage in your state. If this happens, we will notify you at least 180 days in advance;
6. The date you are on or begin full-time active duty with a United States military service, military reserves, or National Guard, if the time of duty is for more than 31 days;
7. The date you fail to cooperate with a claim investigation; or
8. The date you die.

The termination date for the above events (1 through 7) is the first of the month following the termination event.

Insurance will terminate at 12:01 a.m. Central Standard Time on the termination date of coverage.

However, if the termination is due to fraud or an intentional misrepresentation of a material fact under the terms of insurance under the Plan, we may void the insurance. Void means that the insurance was never in effect.

If we void insurance, we will return to you all Premiums we received, less the amount of any claims we paid, for you and your insured Dependents under the Plan. We reserve the right to recover any claims amount that exceeds the Premiums we received.

Termination of Insurance for Your Dependents

Insurance terminates for a Dependent when the first of the following events happens:

1. The date you request termination of insurance for a Dependent. You may terminate insurance at any time by providing us with written notice prior to the requested termination date;
2. The due date we do not receive the required Premium for the Dependent;

3. The date the Dependent is on or begins full-time active duty with a United States military service, military reserves, or national guard, if the time of duty is for more than 31 days;

4. The date the Dependent no longer satisfies the Policy definition of Dependent;

5. For an adopted child, the date placement is terminated and the adoption is not made final;

6. For a foster child, the date foster care is terminated;

7. For a child for whom you have legal guardianship, the date guardianship terminates;

8. The date your Dependent performs an act or practice that is fraudulent, or makes an intentional misrepresentation of a material fact under the terms of insurance under the Plan; or

9. The date your Dependent dies.

The termination date for the above events (1 through 8) is the first of the month following the termination event.

Insurance will terminate at 12:01 a.m. Central Standard Time on the termination date.

However, if the termination is due to fraud or an intentional misrepresentation of a material fact under the terms of insurance under the Plan, we may void the insurance. Void means that the insurance was never in effect.

Notification of Plan Termination

We will notify you when the Plan terminates due to any of the reasons listed in the Termination of Insurance section in the Policy.

Reinstatement

Insurance terminated for the Policyholder may be reinstated subject to Our written approval and receipt of all required Premiums. Reinstatement is limited to once every 12 months. The insurance is effective on the date of reinstatement unless we specify another date.

Reapplying after Termination

If you terminate Coverage, you must wait 12 months until you may again apply for Coverage.

Section 3.3 Extended Coverage for Handicapped Dependent Children

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

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

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

C. Proof of such incapacity and dependence is furnished to the Company within 60 days of the date the Policyholder receives a request for such proof from the Company; and

D. Payment of any required Premium for the Enrolled Dependent is continued.

You will be notified 90 days prior to the Enrolled Dependent's attainment of the limiting age.

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

Section 3.4 Payment and Reimbursement Upon Termination

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

Section 4: Reimbursement

Section 4.1 Reimbursement of Eligible Expenses

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

Section 4.2 Filing Claims for Reimbursement of Eligible Expenses

The Company, upon receipt of a notice of claim, will furnish you such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, you will be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

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

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

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

Payment of Claims. Benefits are payable in accordance with any state prompt pay requirements after the Company receives proof of loss. When you obtain Covered Dental Services from Non-Network Dentists, you must file a claim with the Company unless:

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

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

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

Section 4.3 Limitation of Action for Reimbursement

You do not have the right to bring any legal proceeding or action against the Company to recover reimbursement until 90 days after you have properly submitted a request for reimbursement, as described above. If you do not bring such legal proceeding or action against the Company within 3 years from the date written proof of loss was submitted to us, you forfeit your rights to bring any action against the Company.

Section 5: Complaint Procedures

Section 5.1 Complaint Resolution

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

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

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

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

We will notify you of our decision regarding our reconsideration of your complaint within 60 days of receiving it. If you are not satisfied with our decision, you have the right to take your complaint to the California Department of Insurance. The address is 300 Capitol Mall, Suite 1700, Sacramento, CA, 95814. The phone number is 916-492-3500.

Section 5.2 Complaint Hearing

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

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

We will send you written notification of the committee's decision within 30 days of the conclusion of the hearing. If you are not satisfied with our decision, you have the right to take your complaint to the California Department of Insurance. The address is 300 Capitol Mall, Suite 1700, Sacramento, CA, 95814. The phone number is 916-492-3500.

Section 5.3 Exceptions for Emergency Situations

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

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

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

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

If you are not satisfied with our decision, you have the right to take your complaint to the California Department of Insurance. The address is 300 Capitol Mall, Suite 1700, Sacramento, CA, 95814. The phone number is 916-492-3500.

Section 6: General Provisions

Section 6.1 Entire Policy

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

Section 6.2 Limitation of Action

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

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

Section 6.3 Time Limit on Certain Defenses

No statement, except a fraudulent statement, made by the Policyholder will be used to void the Policy after it has been in force for a period of 3 years.

Section 6.4 Amendments and Alterations

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

Section 6.5 Relationship Between Parties

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

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

Section 6.6 Information and Records

At times the Company may need additional information from you. You agree to furnish the Company with all information and proofs that the Company may reasonably require regarding any matters pertaining to the Policy. If you do not provide this information when the Company requests it we may delay or deny payment of your Benefits.

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

Policyholder's application form. The Company agrees that such information and records will be considered confidential.

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

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

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

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

Section 6.7 Examination of Covered Persons

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

Section 6.8 Clerical Error

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

Section 6.9 Workers' Compensation Not Affected

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

Section 6.10 Conformity with Statutes

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

Section 6.11 Headings

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

Section 6.12 Unenforceable Provisions

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

Section 6.13 Other Insurance for Dental Services

If any Covered expenses under this Policy are also payable under health or other dental insurance or other health coverage, we will not make payment under this dental Policy until after we determine what benefits are paid or payable by the health insurance or other dental or health coverage plan.

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

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

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

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

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

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

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

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

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

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

            1.) The parents are married;

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

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

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

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

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

   1.) The Coverage Plan of the custodial parent;

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

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

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

Section 7: Premiums

Section 7.1 Premium Payments

We must receive the required Premiums by the due date. We will tell you where to send the payment. The first payment is due on the effective date. Unless we specify otherwise, the due date for each Premium payment thereafter is the first day of each calendar month.

This Plan may require monthly, quarterly, semi-annual, or annual Premium payment. Failure to pay accordingly may result in termination of the Policy.

Administrative, service, and/or policy fees, where allowable by law, are due and payable on the due date. If fees are not paid, the Policy may be subject to termination.

We will not accept payment made to any person who is not authorized in writing by us to accept Premium payments for us. We have the right to charge a fee for late payment.

If payment is made by check, payment is not made if the check is not honored by the bank. We reserve the right to return a check issued with insufficient funds, without making a second deposit attempt.

Section 7.2 Grace Period

You have a 31-day grace period for the payment of each Premium due after the first Premium. Your coverage will continue in force during the grace period unless you have given us prior written notice of termination. If such a Premium is not received by us by the end of the grace period, all such insurance will end as of the due date of such Premiums, and no expenses Incurred during the grace period will be considered for benefits. We reserve the right to recover any amounts Incurred and paid during the grace period.

Section 7.3 Premium Changes

Premium rates are calculated based on a variety of factors. As allowed by state law, these factors may include geographic location, provider network, distribution channels, selected benefits, age, gender, tobacco use, classes, health status of you and your insured Dependents, length of time you are insured under the plan, health status of the entire pool of insureds in which you are included, administrative costs, occupation, industry, and other factors.

Your Premium rates, administrative fees and/or service fees are guaranteed for 12 months from your coverage effective date, except when:

1. Your residence changes;
2. You or your insured Dependent attain a higher age;
3. A Dependent is added to or terminated from the plan; or
4. Any benefit is changed including, but not limited to, increases or decreases in a benefit or the addition or removal of a benefit from the plan.

We reserve the right to change the Premium rates, the administrative fees, and/or the service fees on the next Premium due date when one of the above-mentioned events occurs. We will notify you about the change as soon as possible.

Premiums, administrative fees and/or service fees may also change at your renewal date. We will provide you with advance written notice a minimum of 30 days prior to the effective date of the change unless state law requires additional notice.

If we find that Premiums, administrative fees, and/or service fees are incorrect, we will:

1. Make a refund to you for any amount of overpaid Premiums; or
2. Request a payment from you for any amount of underpaid Premiums.

Section 7.4 Return of Premium for Voided Insurance

We may void insurance for you or your Dependent as allowed under the Time Limit on Certain Defenses provision of this Policy. When this happens:

1. If we did not receive any claims for you or your Dependent prior to the void date, we will refund all Premiums paid for you or your Dependent; or
2. If we received claims that we must pay for you or your Dependent prior to the void date, we reserve the right to subtract from the refund the amount of claims that we must pay.

We reserve the right to recover the amount of any claims we paid or costs incurred by us that exceed the Premium refund.

Section 8: Refund of Expenses

Reimbursement of Benefits Paid. If the Company pays benefits for expenses incurred on account of a Covered Person, the Policyholder or any other person or organization that was paid must make a refund to the Company if all or some of the expenses were recovered from or paid by a source other than the Policy as a result of claims against a third party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount the Company paid.

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

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

Section 9: Procedures for Obtaining Benefits

Section 9.1 Dental Services

You are eligible for Coverage for Dental Services listed in the *Schedule of Covered Dental Services* and *Section 10: Covered Dental Services* of this *Policy* if such Dental Services are Necessary and are provided by or under the direction of a Dentist or other provider. All Coverage is subject to the terms, conditions, exclusions and limitations of the Policy.

Network Benefits

Dental Services must be provided by a Network Dentist in order to be considered Network Benefits.

When Dental Services are received from a Non-Network Provider as a result of an Emergency, the Copayment or Plan Allowance will be the Network Copayment or Plan Allowance.

Enrolling for Coverage under the Policy does not guarantee Dental Services by a particular Network Dentist on the list of providers. The list of Network Dentists is subject to change. When a provider on the list no longer has a contract with the Company, you must choose among remaining Network Dentists. You are responsible for verifying the participation status of the Dentist, or other provider prior to receiving such Dental Services. You must show your ID card every time you request Dental Services.

If you fail to verify participation status or to show your ID card, and the failure results in non-compliance with required Company procedures, Coverage of Network Benefits may be denied.

Coverage for Dental Services is subject to payment of the Premium required for Coverage under the Policy, satisfaction of the Deductible, appropriate Waiting Period, payment of the Copayment specified for any service and payment of the percentage of Eligible Expenses shown in the *Schedule of Covered Dental Services* and *Section 10: Covered Dental Services*.

Non-Network Benefits

Non-Network Benefits apply when you obtain Dental Services from Non-Network Dentists.

Before you are eligible for Coverage of Dental Services obtained from Non-Network Dentists, you must meet the requirements for payment of the Deductible and appropriate Waiting Period specified in the *Schedule of Covered Dental Services* and *Section 10: Covered Dental Services*. Non-Network Dentists may request that you pay all charges when services are rendered. You must file a claim with the Company for reimbursement of Eligible Expenses.

The Company reimburses a Non-Network Dentist for a covered Dental Service up to an amount equal to the contracted fee for the same covered Dental Service received from a similarly situated Network Dentist.

Network Dentists

The Company has arranged with certain dental care providers to participate in a Network. These Network Dentists have agreed to discount their charges for Covered services and supplies.

If Network Dentists are used, the amount of Covered expenses for which a Covered Person is responsible will generally be less than the amount owed if Non-Network Dentists had been used. The Copayment level (the percentage of Covered expenses for which a Covered Person is responsible) remains the same whether or not Network Dentists are used. However, because the total charges for Covered expenses may be less when Network Dentists are used, the portion that the Covered Person owes will generally be less.

Covered Persons are issued an identification card (ID card) showing they are eligible for Network discounts. A Covered Person must show this ID card every time Dental Services are given. This is how

the provider knows that the patient is Covered under a Network plan. Otherwise, the person could be billed for the provider's normal charge.

A Directory of Network Dentists will be made available. A Covered Person can also call customer service to determine which providers participate in the Network. The telephone number for customer services is on the ID card.

Network Dentists are responsible for submitting a request for payment directly to the Company, however, a Covered Person is responsible for any Copayment at the time of service. If a Network Dentist bills a Covered Person, customer services should be called. A Covered Person does not need to submit claims for Network Dentist services or supplies.

Section 9.2 Pre-Treatment Estimate

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

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

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

Section 10: Covered Dental Services

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

A. Necessary;

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

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

D. Not excluded as described in *Section 10: General Exclusions*.

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

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

Network Benefits:

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

A Network provider cannot charge a Covered Person or the Company for any service or supply that is not Necessary as determined by the Company. If a Covered Person agrees to receive a service or supply that is not Necessary the Network provider may charge the Covered Person. However, these charges will not be considered Covered Dental Services and will not be payable by the Company.

Non-Network Benefits:

When Copayments are charged as a percentage Eligible Expenses, the amount you pay for Dental Services from Non-Network providers is determined as a percentage of the negotiated contract rates of Network providers plus the amount by which the Non-Network provider's billed charge exceeds the contracted fee.

Deductible

Deductible is $25 per Covered Person for Network Benefits and $25 per Covered Person for Non-Network Benefits per calendar year.

The Deductible for Network Benefits applies to any combination of the following Covered Dental Services: DIAGNOSTIC SERVICES, PREVENTIVE SERVICES, MINOR RESTORATIVE SERVICES, PERIODONTICS.

The Deductible for Non-Network Benefits applies to any combination of the following Covered Dental Services: DIAGNOSTIC SERVICES, PREVENTIVE SERVICES, MINOR RESTORATIVE SERVICES, PERIODONTICS.

Maximum Benefit

Maximum Benefit is $1,000 per Covered Person per calendar year.

Maximum Benefit applies to any combination of the following Covered Dental Services: DIAGNOSTIC SERVICES, PREVENTIVE SERVICES, MINOR RESTORATIVE SERVICES, PERIODONTICS.

Section 11: General Exclusions

Section 11.1 Exclusions

Except as may be specifically provided in the Schedule of Covered Dental Services or through a Rider to the Policy, the following are not Covered:

A. Dental Services that are not Necessary.

B. Hospitalization or other facility charges.

C. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

D. Any Dental Procedure not performed in a dental setting.

E. Procedures that are considered to be Experimental, Investigational or Unproven.

F. Placement of dental implants, implant-supported abutments and prostheses.

G. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

H. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

I. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

J. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

K. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.

L. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

M. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.

N. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

O. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.

P. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.

Q. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

R. Orthodontic Services.

S. In the event that a Non-Network Dentist routinely waives Copayments and/or the Deductible for a particular Dental Service, the Dental Service for which the Copayments and/or Deductible are waived is reduced by the amount waived by the Non-Network provider.

T. Foreign Services are not Covered unless required as an Emergency.

U. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

V. Any Dental Services or Procedures not listed in the *Schedule of Covered Dental Services*.

SCHEDULE OF COVERED DENTAL SERVICES

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
DIAGNOSTIC SERVICES		
Panorex Radiographs Limited to 1 time per consecutive 36 months.	0%	0%
Extraoral Radiographs Limited to 2 films per calendar year.	0%	0%
Intraoral - Complete Series (including bitewings) Limited to 1 time per consecutive 36 months. Vertical bitewings can not be billed in conjunction with a complete series.	0%	0%
Intraoral Periapical Radiographs	0%	0%
Periodic Oral Evaluation Limited to 2 times per consecutive 12 months.	0%	0%
Comprehensive Oral Evaluation Limited to 2 times per consecutive 12 months. Not Covered if done in conjunction with other exams.	0%	0%
Limited or Detailed Oral Evaluation Limited to 2 times per consecutive 12 months. Only 1 exam is Covered per date of service.	0%	0%
PREVENTIVE SERVICES		

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Dental Prophylaxis Limited to 2 times per consecutive 12 months.	0%	0%
MINOR RESTORATIVE SERVICES		
Amalgam Restorations Multiple restorations on one surface will be treated as a single filling.	20%	20%
Composite Resin Restorations - Anterior Multiple restorations on one surface will be treated as a single filling.	20%	20%
PERIODONTICS		
Periodontal Maintenance Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.	50%	50%
Full Mouth Debridement Limited to once per consecutive 36 months.	50%	50%
Scaling and Root Planing Limited to 1 time per quadrant per consecutive 24 months.	50%	50%

NOTICE OF PRIVACY PRACTICES

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

Effective: April 14, 2003

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

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

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

*For purposes of this Notice of Privacy Practices, "we" or "us" refers to the following entities: Dental Benefit Providers of California, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company; and Unimerica Life Insurance Company of New York.

How We Use or Disclose Information

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

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

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

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

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

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

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

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

Highly Confidential Information

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

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

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

What Are Your Rights

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

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

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

Exercising Your Rights

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

Unimerica Life Insurance Company

Liberty 6, Suite 200

6220 Old Dobbin Lane

Columbia, MD 21045

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

Financial Information Privacy Notice

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

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

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

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

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

**For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities on the first page of the Notice of Privacy Practices, plus the following affiliates: Dental Benefit Providers, Inc.*

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

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

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

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

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