Summary of Benefits
MAGNUM 1

	In-Network Fee Schedule	Out-of-Network R & C
Preventive		
Diagnostic-Preventive Preventive Exams, Cleanings (2 per year), Fluoride, X-rays (except for Panoramic), etc...	100% Deductible Applies	100% Deductible Applies
Basic (Fillings - alternate benefit applies)		
Adjunctive Services-Basic Diagnostic-Basic, Preventive-Basic (Sealants, Space Maintainers), Restorative-Basic	90% Deductible Applies	80% Deductible Applies
Major		
Adjunctive Services-Major Endodontics, Oral and Maxillofacial Surgery, Periodontics, Prosthodontics-Fixed, Prosthodontics-Removable, Restorative-Major Panoramic X-rays	60% Deductible Applies 12 Month Waiting Period	50% Deductible Applies 12 Month Waiting Period
Orthodontics		
Orthodontics	0%	0%
Maximums		
Preventive, Basic, & Major Per Member: Per Effective Date **Maximum Rollover Provision Applies**. Member's Annual Maximum increases incrementally each year, until Annual Maximum reaches $2,000.00. See Schedule of Benefits.	$2000.00 per year Initial Annual Maximum	$2000.00 per year Initial Annual Maximum
Orthodontic Lifetime Maximum	$0	$0
Deductibles		
Per Person / Per Family (Lifetime Deductible)	$100\0	$100\0
Specialists		
	Specialists - Plan payment details on the following page.	

Please refer to the next page for additional plan notes.

PLAN NOTES

Network (Contracted) General Dentist Services: All payments made by the Plan for services provided by Contracted General Dentists are based on the provider's contracted fee schedule, as follows:

- **California** – First Dental Health Network General Dentists accept the First Dental Health fee schedule as payment in full.
- **Minnesota** – Premier Network General Dentists accept the Premier fee schedule as payment in full.
- **Nevada** – Diversified Network General Dentists accept the Diversified fee schedule as payment in full.
- **Texas** – *Two provider networks are used in Texas, the Dental Select Network and the Connection Dental Network.* Dental Select Network's Contracted General Dentists accept the Dental Select Platinum fee schedule as payment in full; Connection Dental Network's Contracted General Dentists accept the Connection Dental fee schedule as payment in full.
- **Utah** – Dental Select Network General Dentists accept the Dental Select Platinum fee schedule as payment in full.
- **All other states** – Connection Dental Network General Dentists accept the Connection Dental fee schedule as payment in full.

Network (Contracted) Specialist Services: All payments made by the Plan for services provided by Contracted Specialists are based on the provider's contracted fee schedule, as follows:

- **California** – First Dental Health Network Specialists accept the First Dental Health fee schedule as payment in full.
- **Minnesota** – Premier Network Specialists accept the Premier fee schedule as payment in full.
- **Nevada** – Diversified Network Specialists accept the Diversified fee schedule as payment in full.
- **Texas** – *Two provider networks are used in Texas, the Dental Select Network and the Connection Dental Network. Please note, the method of reimbursement for Contracted Specialists varies between the two provider networks.*

  Dental Select Network of Contracted Specialists in Texas – Services rendered will be reimbursed as follows:
  1. The Insured receives a 20% discount from the Contracted Specialist's usual fees for eligible services.
  2. After the deductible, the Plan pays Dental Select Network's Contracted Specialists according to the Dental Select Platinum fee schedule. The Insured is responsible for the difference between the discounted fee and the Plan's payment.

  Connection Dental Network of Contracted Specialists in Texas – Connection Dental Network's Contracted Specialists accept the Connection Dental fee schedule as payment in full. There is no additional discount. The maximum charge allowed for orthodontia services performed by Connection Dental Network's Contracted Orthodontists is $3,800.00.
- **Utah** – Services rendered by a Dental Select Network Specialist will be reimbursed as follows:
  1. The Insured receives a 20% discount from the contracted specialist's usual fees for eligible services.
  2. After the deductible, the Plan pays Contracted Specialists according to the Dental Select Platinum fee schedule. The Insured is responsible for the difference between the discounted fee and the Plan's payment.
- **All other states** – Connection Dental Network Specialists accept the Connection Dental fee schedule as payment in full. The maximum charge allowed for orthodontia services performed by Connection Dental Network Orthodontists is $3,800.00.

Fee Schedules are subject to change upon notification.

If full payment of the Insured's co-payment is not made to the Network (Contracted) provider within 90 days, the provider may bill the Insured his/her standard fees.

Use of a Network (Contracted) provider does not guarantee that all charges will be covered under the Policy. Charges are subject to all terms and conditions of the Policy.

Non-Network (Non-Contracted) General Dentist and Specialist Services: All payments made by the Plan for services provided by Non-Network (Non-Contracted) General Dentists and Specialists are based on R&C. Charges above the Plan's payment are the Insured's responsibility.

ACE American Insurance Company
Philadelphia, PA 19106

YOUR INSURANCE CERTIFICATE

General Information About Your Insurance

This Certificate explains the plan of insurance underwritten by ACE American Insurance Company. Read it closely to become familiar with Your coverage.

Important Notice

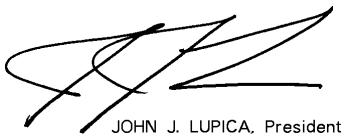
Benefits are payable only for expenses incurred while Your insurance is in force.

No agent has the right to change the Policy or to waive any part of it.

The Policy, under which this Certificate is issued, may be amended or canceled at any time as stated in its provisions. Such an action may be taken without the consent of or notice to any person who claims rights or benefits under the Policy.

The insurance under the Policy does not take the place of nor does it affect any requirements for coverage by Worker's Compensation or a similar type of insurance.

Signed for ACE American Insurance Company at Philadelphia, Pennsylvania.



JOHN J. LUPICA, President

CARMINE A. GIGANTI, Secretary

GROUP DENTAL

TABLE OF CONTENTS

Definitions 3

Conditions for Insurance 4

Dental Insurance 5

COBRA Continuation of Benefits 6

Coordination of Benefits 7

General Provisions 8

Right of Refund 8

Group Dental Schedule of Benefits 9

Summary of Benefits ..... ENCLOSED

DEFINITIONS

These definitions apply when the following terms are used in this Certificate

ADA CODE: means the American Dental Association Code assigned to a particular dental procedure.

CO-PAYMENT / DEDUCTIBLE: means the amount You must pay toward the cost of an ELIGIBLE EXPENSE.

COURSE OF TREATMENT: means all treatment and procedures performed in the oral cavity under a plan of treatment during one or more sessions that are the result of the same initial diagnosis. It also includes any complications during such treatment.

CUSTOMARY FEE: the fee level determined by the administrator of a dental benefit plan from actual submitted fees for a specific dental procedure to establish the maximum benefit payable under a given plan for that specific procedure.

DENTAL HYGIENIST: means a person who works under the supervision of a Dentist/Physician and who is currently licensed to practice dental hygiene.

DEPENDENT: means any of the following persons:
1. Your legal spouse.
2. Each unmarried child, from birth to age 25.
3. Each unmarried child at least 25 years of age:
    a. who is dependent upon You for support because he is incapable of self-sustaining employment by reason of mental retardation or physical handicap;
    b. who was incapacitated and insured under the Policy on his 25th birthday; and who continues to be incapacitated beyond his 25th birthday. You must give Us proof of the incapacity and dependency within 30 days of the child's 25th birthday. We may require further proof at any time after that. We may not require this more often than annually after two years.

A child, for eligibility purposes, includes an Insured's natural child, stepchild, adopted child, or grandchild who is financially dependent on you and resides with you.

DOMESTIC PARTNER: means a person who:
1. Shares the Insured's permanent residence;
2. Has resided with the Insured for at least 12 months prior to the date of enrollment and is expected to continue to reside with the Insured indefinitely;
3. Is financially interdependent with the Insured in each of the following ways:
    a. by holding one or more credit or bank accounts, including a checking account, as joint owners;
    b. by owning or leasing their permanent residence as joint tenants;
    c. by naming, or being named by, the Insured as a beneficiary of life insurance or under a will;
    d. by each agreeing in writing to assume financial responsibility for the welfare of the other.
4. Has signed a Domestic Partner declaration with the Insured, if the Insured resides in a jurisdiction which provides for Domestic Partner declarations;
5. Has not signed a Domestic Partner declaration with any other person within the last 12 months;
6. Is older than 18 years old, but no more than 70 years old;
7. Is legally prohibited from marrying the Insured:
8. Is not currently legally married to any other person; and
9. Is not a blood relative any closer than would prohibit legal marriage.

ELIGIBLE EXPENSES: means those dental services described in this Certificate as being eligible for coverage.

EMERGENCY: means a dental condition of an unforeseen nature which requires immediate dental treatment.

EMPLOYEE: means a permanent full-time employee of the employer working required hours per week on a regular basis.

INSURED: means You and Your Dependents who meet the eligibility requirements of the Policy and for whom the applicable premium has been paid.

NETWORK GENERAL DENTIST: means a licensed dentist who agrees to provide services to a specific pool of patients at an agreed upon fee-for-service rate.

NON-NETWORK DENTIST: means a licensed dentist who has not agreed to provide services to a specific pool of patients at an agreed upon fee-for-service rate.

POLICY: means the Policy issued to the Policyholder.

QUALIFYING EVENT: means one of the following life status changes: Marriage, Divorce, or Legal Separation, Birth of a Child or Adoption of a Child, Loss of Employment, New Employment, Death of Insured.

REASONABLE FEE: the fee charged by a dentist for a specific dental procedure that has been modified by the nature and severity of the condition being treated and by any medical or dental complications or unusual circumstances, and therefore may differ from the dentist's "usual" fee or the benefit administrator's "customary: fee.

SPECIALIST: means a licensed dentist who is board certified in one or more of the following specialties: Endodontics, Periodontics, Pedodontics, Prosthodontics, Oral Surgery, Orthodontics and any other board certified specialty outside of general dentistry.

SUMMARY OF BENEFITS: means a description of Your benefits including coverage level for services, deductibles, maximums, waiting periods, etc.

USUAL AND CUSTOMARY (U&C): means the usual, customary and reasonable charges for the area where such expenses are incurred.

WAITING PERIOD: means the time period between the effective date of dental coverage and the date when a member is eligible for benefits in a specific class.

WE, OUR, US: means ACE American Insurance Company.

YOU, YOUR, YOURS: means the certificate holder.

CONDITIONS FOR INSURANCE

WHO IS ELIGIBLE FOR COVERAGE: You and Your Dependents are eligible to be insured on the later of: 1) the Policy Effective Date; or 2) the day after You complete the Eligibility Waiting Period, if later.

We maintain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

ENROLLMENT: You and Your Dependents may enroll for coverage within 31 days of becoming eligible for coverage through Your employer, during Your employer's open enrollment period or, within 31 days of a Qualifying Event.

EFFECTIVE DATE: You and Your Dependents are covered on the later of:
1. the date You and Your Dependents become eligible for coverage provided You enroll within 31 days of that date;
2. the first day of the month following the Employer's annual renewal date if You fail to enroll You and/or Your Dependents within 31 days of that date You and/or Your Dependents first become eligible; or
3. the date You first acquire a new Dependent, provided You enroll within 31 days of that date.

NEWBORN INFANT COVERAGE: A Dependent child born is covered from the moment of birth while the policy is in force. If the Insured has elected coverage for a Dependent child, any newly born child will be covered from the moment of birth. If additional premium is required for each Dependent child, We may withhold payment of any benefits for the new Dependent until the required premium is paid.

ADOPTED CHILDREN COVERAGE: A Dependent child placed with You for adoption is covered from the date of such placement while the policy is in force. In the case of adoption of a newborn child, coverage will begin from the moment of birth if placement for adoption occurs within 31 days of the child's birth. Such coverage will continue, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

A notice of placement for adoption together with the premium must be submitted to Us. This must be done within 31 days after the date of such placement to continue coverage beyond the 31-day period.

If You fail to enroll Your newborn child or adopted child within this period You will have 31 days after the date the child's first claim is denied to enroll the child for coverage.

DOMESTIC PARTNER PROVISION: An Insured may elect coverage for a Domestic Partner if all of the following conditions are met:
1. The Insured has not been married to any person within the past 12 months.
2. The Domestic Partner is the only person meeting the Policy's definition of "Domestic Partner" with respect to the Insured.
3. The Insured and Domestic Partner furnish a notarized affidavit or signed statement reflecting these requirements, and an agreement to notify the Company if the requirements cease to be met, on a form acceptable to the Company.

In addition to the above requirements, consent of either party to the Domestic Partner relationship must not have been obtained by force, duress, or fraud.

To obtain insurance for a Domestic Partner, the Insured must request coverage in writing and agree to make any required premium contribution. Insurance will be effective on the first day of the month after We receive a signed request and all required information.

The amount of insurance with respect to any Domestic Partner is as shown in the Schedule.

COURT OR ADMINISTRATIVE ORDER: When a parent is required by court or administrative order to provide health coverage for a child, and the parent is eligible for Dependent coverage under the plan, We will not deny enrollment of the child on the grounds that the child:
1. was born out of wedlock and is entitled to coverage though the non- custodial parent;
2. was born out of wedlock and the custodial parent seeks enrollment for the child under the custodial parent's plan;
3. is not claimed as a dependent on the parent's federal tax return; or
4. does not reside with the parent or in the plan's service area.

PREMIUMS: Premiums are payable on a monthly basis, unless We agree to some other mode of payment. Premium must be paid to Us at Our Home Office or to Our authorized administrator. The payment of any premium will keep Your coverage in force to the next premium due date, subject to the Termination provision.

TERMINATION: You and Your dependents may terminate Your coverage during Your employer's open enrollment period or, within 31 days of a Qualifying Event.

YOUR INSURANCE ENDS: Insurance for You and Your Dependents will end on the earliest of:
1. the last day You cease to be eligible;
2. the last day Your Dependent ceases to be a Dependent, as defined;
3. the last day of the month for which a premium has been paid; or
4. the date the policy ends.

If Your coverage ends it will not prejudice any existing claim.

VOLUNTARY TERMINATION: If You voluntarily terminate Your insurance without a qualifying event and wish to re-enroll at a later date, We reserve the right to require a two year waiting period. Your two year waiting period will begin on the date You first terminated Your insurance.

If Your coverage ends it will not prejudice any existing claim. If You terminate Your insurance and wish to re-enroll at a later date, We reserve the right to require a two-year waiting period. Your two-year waiting period will begin on the date You first terminated Your insurance.

CONTINUATION OF INSURANCE: Insurance for Your Dependents may be continued if insurance would otherwise end because of Your death. In this event, to continue insurance a Dependent must:
1. submit a written (or authorized electronic/telephonic) request for continued insurance within 31 days of Your death;
2. meet all other eligibility requirements; and
3. pay the required premium.

Insurance continued in this way will end of the first of the following dates to occur:
1. the date the surviving spouse becomes covered under another group dental plan; or
2. the date coverage would have terminated under this policy, had the Insured lived.

GRACE PERIOD: If any premiums are not paid by the Premium Due Date, a Grace Period of 31 days will be granted for the payment of the required premiums. Coverage under the Policy will remain in force during the Grace Period. If the required premiums are not paid during the Grace Period, insurance will end as of the last day of the period for which premiums were paid. You will be liable to Us for any unpaid premium for the time coverage under the Policy was in force.

RECOVERY OF OVERPAYMENT: If benefits are overpaid, or paid in error, We have the right to recover the amount overpaid, or paid in error, by any of the following methods:
1. A request for lump sum payment of the amount overpaid, or paid in error;
2. Reduction of any proceeds payable under the Policy by the amount overpaid, or paid in error;
3. Any other method otherwise available to the Company.

DENTAL INSURANCE

ELIGIBLE EXPENSES: We will pay for Eligible Expenses You incur for Yourself or on behalf of Your insured Dependent. Expenses must be incurred while the Policy is in force and You are covered by the Policy. The description of Eligible Expenses is shown in the Coverage Schedule.

To be an Eligible Expense, the dental service or procedure must be performed by:
1. a Dentist;
2. a Physician; or
3. a Dental Hygienist.

EXPENSES INCURRED: An Eligible Expense is considered incurred on the following dates:
1. For dentures, partial dentures, and fixed bridges - seat date (date restoration is placed).
2. For crowns, inlays and onlays - the date the teeth are first prepared.
3. For root canal therapy - the date the pulp chamber is opened.
4. For periodontal surgery - the date surgery is performed.
5. For orthodontic services - benefit is considered as follows: Records- on the date the service is performed; Initial banding - on the date bands are inserted; Monthly treatments - on the date the service is performed.
6. For all other services - the date the service is performed.

MAXIMUM CONTRACT/CALENDAR YEAR LIMIT: The maximum limit payable for all Eligible Expenses in any calendar/contract year is shown in the Coverage Schedule. The Maximum Calendar/Contract Year Limit, if any, will apply to each person covered under the Policy.

DEDUCTIBLE: The lifetime and calendar/contract year Deductible, if any, is shown in the Coverage Schedule. The Deductible is an amount of charges You must incur for Yourself or on behalf of Your insured Dependent before We start paying benefits.

NETWORK GENERAL DENTIST SERVICES: In-network general dentists accept the contracted fee schedule as payment in full. The negotiated fees are subject to change without notice. Services not listed in the Provider's contracted fee schedule are available on a fee-for service basis and are the patient's full responsibility.

Use of a Network General Dentist does not guarantee that all charges will be covered under the Policy. All charges are subject to all terms and conditions of the Policy.

NETWORK SPECIALIST SERVICES: A Specialist is a licensed dentist who is board certified in one or more of the following specialties: Endodontics, Periodontics, Pedodontics, Prosthodontics, Oral Surgery, Orthodontics, and any other board certified specialty outside of general dentistry.

Network Specialists have agreed to provide services at a discount from their usual fees. The discounted rate is based on the negotiated agreement in the provider's contract. Services rendered by a Network Specialist will be reimbursed as stated in the Coverage Schedule.

Use of a Network Specialist does not guarantee that all charges will be covered under the Policy. All charges are subject to all terms and conditions of the Policy.

NON-NETWORK GENERAL DENTIST & SPECIALIST SERVICES: Non-network Dentists and Specialists do not accept Our contracted fee schedule as payment in full. Services will be reimbursed as stated in the Coverage Schedule. The fact that a Dentist, Hospital, or other Provider may prescribe, order, recommend, or approve a service or supply, does not, of itself, make it Medically Necessary or make the charge an allowable expense. We determine if a service or supply is covered in accordance with established Plan benefit and eligibility criteria and policies.

PRE-DETERMINATION REVIEW: We recommend You receive a pre-determination if the Course of Treatment is expected to exceed $300. The Dentist's treatment plan consisting of a description of the planned treatment with estimated charges and diagnostic x-rays is required for the review. We will determine Eligible Expenses and state how much We will pay for the treatment. Our determination may suggest an alternate, less expensive Course of Treatment if it will produce professionally-satisfactory results. Failure to obtain a pre-determination may result in additional out-of-pocket expenses for You if an alternate, less expensive treatment is available but not used.

ALTERNATE BENEFIT: If: 1) We determine that a less expensive alternate procedure, service or Course of Treatment can be performed in place of the proposed treatment to correct a dental condition; and 2) the alternative treatment will produce a professionally satisfactory result; then the maximum We will allow will be the charge for the less expensive treatment.

COBRA CONTINUATION OF BENEFITS
(Employers of 20 or more employees)

APPLICABILITY: Federal Law requires that employers of 20 or more employees offer temporary extension of health coverage to Qualified Beneficiaries of employees employed at least 50% of the preceding year when coverage would otherwise end because one or more of the Qualifying Events listed below occurs. Under COBRA, a Qualified beneficiary is any individual who, on the day before a Qualifying Event, is covered under the Policy and is not 1) already covered under the Policy by reason of another individual's election of COBRA Continuation Benefits, or 2) entitled to Medicare benefits under Title XVIII of the Social Security Act.

QUALIFYING EVENT: For purposes of coverage under COBRA, the term Qualifying Event means, with respect to any Insured, any of the following events that, but for the continuation coverage required under the law, would result in the loss of coverage for a Qualified Beneficiary.

Qualifying Event	Coverage Continuation Period
• Death of an Insured; divorce or legal separation; an insured Dependent no longer meets the eligibility requirements	36 months
• The Insured becomes eligible for Medicare	Dependents allowed 36 months
• Termination of employment for any reason except gross misconduct, or the reduction in hours that would result in loss of coverage	18 months*

*Coverage may be continued for an additional 11 months if the Qualified Beneficiary:
1. Is determined disabled for Social Security purposes at the time of the Qualifying Event or within 60 days after continuation coverage begins; and
2. Notifies the plan administrator within 60 days from determination but before the 18-month continuation period begins.

Beneficiaries may be covered by more than one Qualifying Event. However, in no event may the total continuation period exceed 36 months from all Qualifying Events.

NOTICE AND ELECTION: Insured are responsible for notifying their employer in the case of divorce, legal separation, cessation of dependency or determination of disability by the Social Security Administration. The employer must notify the plan administrator of the Qualifying Event. The employer must notify the Qualified Beneficiaries of their COBRA election rights. The period during which the Qualified Beneficiary must elect or decline continuation of coverage under COBRA ends not earlier than 60 days after the later of 1) the date that coverage would end under the Policy by reason of a Qualifying Event, or 2) the date the Qualified Beneficiary receives notice of their COBRA election rights from the plan administrator.

PREMIUM PAYMENT: The Qualified Beneficiary must pay to the employer the required monthly premium. Any Grace Period applying to the employer will also apply to the Qualified Beneficiary, except for the first premium payment. Payment of premium for coverage under the period preceding the election must be made within 45 days of the date of the election.

TERMINATION OF CONTINUED BENEFITS: Benefits continued under COBRA will end on the first date that one of the following events occurs:
1. The premium for continued coverage is not paid within 31 days from when it is due;
2. The Qualified Beneficiary becomes covered under another group medical plan providing the same or similar benefits, if that plan does not contain any exclusion or limitation on an pre-existing conditions of the Qualified Beneficiary;
3. The Qualified Beneficiary becomes eligible for Medicare;
4. The Qualified Beneficiary, who is divorced from an insured employee, remarries and is covered under the new spouse's medical plan; or
5. The employer no longer provides dental benefits of any kind.

PREMIUMS: Premiums are payable on a monthly basis, unless We agree to some other mode of payment. Premium must be paid to Us at Our Home Office or to Our authorized administrator. The payment of any premium will keep Your coverage in force to the next premium due date, subject to the Termination Provision.

GRACE PERIOD: If any premiums are not paid by the Premium Due Date, a Grace Period of 31 days will be granted for the payment of the required premiums. Coverage under the Policy will remain in force during the Grace Period. If the required premiums are not paid during the Grace Period, insurance will end as of the last day of the period for which premiums were paid. You will be liable to Us for any unpaid premium for the time coverage under the Policy was in force.

COORDINATION OF BENEFITS

COORDINATION OF BENEFITS (COB) & OTHER RECOVERY SYSTEMS

If an Insured is also covered under one or more other plans, this COB provision will apply. COB is the process of determining which of the two or more plans has primary responsibility to pay first and the manner and extent to which the other plans pay or contribute.

DEFINITIONS: for the purpose of this COB provision:

ALLOWABLE EXPENSE: means that amount on which this Plan would base its benefit for any dental charge in the absence of any other coverage when a Plan provides benefits in the form of services, the cash value of each service will be treated as both an Allowable Expense and a benefit paid.

PLAN: means a form of coverage, including coverage under this Policy that provides benefits or services for dental care or treatment. "Plan" includes group insurance and group subscriber contracts; uninsured arrangements of group or group-type coverage; group or group-type coverage through HMOs and other prepayment plans; group-type contracts; medical payments paid by group, group-type and individual automobile "no-fault" medical payment contracts; "Plan" will be treated separately for each contract or other program for benefits or services. "Plan" will be treated separately for that part of a Plan which reserves the right to coordinate with benefits or services of other Plans and that part which does not.

PRIMARY PLAN: means a Plan whose benefits are determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if: 1) it has no order of benefit determination; or 2) all Plans which cover the person have an order of benefit determination rule that determines its benefits first.

SECONDARY PLAN: means a Plan which is not a Primary Plan.

GENERAL RULES

1. The Primary Plan must pay its benefits as if the Secondary Plan did not exist. A Plan that does not a have a COB provision may not take the benefits of another Plan into account when paying benefits.
2. A Secondary Plan may take the benefits of another Plan into account when it is secondary to the other Plan.

ORDER OF BENEFIT DETERMINATION RULES: This Plan determines its order of benefits using the first of rules which follow that apply:

1. A Plan which covers a person as an Employee or Subscriber and not as a Dependent will determine its benefits before a Plan which covers that person as a Dependent.

2. **Dependent Child/Parents Not Separated or Divorced.** The Plan of the parent whose birthday (month and day) falls earlier in a year will determine its benefits before a Plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined first. If the other Plan has a "gender of parent" rule rather than a "birthday" rule and as a result the Plans do not agree on the order of benefits, the rule of the other Plan will apply.

3. **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a Dependent of divorced or separated parents, benefits for the child are determined in this order:

    a. first, the Plan of the parent with custody of the child;
    b. then, the Plan of the spouse of the parent with the custody of the child, and
    c. finally, the Plan of the parent not having custody of the child.

If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. If the parent with financial responsibility has no coverage for the child, but that parent's spouse does, the spouse's Plan is primary. This subparagraph does not apply with respect to any Plan period during which any benefits are actually paid or provided before the entity has that actual knowledge.

If the specific terms of a court decree state that the parents share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the order of benefit determination rules outlined in subparagraph 2 of this section, Dependent Child/Separated or Divorced Parent, will apply.

4. **Active/Inactive Employee.** A Plan which covers a person as an active employee who is neither laid-off nor retired will determine its benefits (for employee and dependents) before those of a plan which covers that same person as a laid-off or retired employee. If the Plans do not agree on the order of benefits because the other Plan does not have this rule, this rule 4 will be ignored.

5. **Longer/Shorter Length of Coverage.** When none of the above rules determine an order of benefits, the Plan which has covered the person for the longer period of time will be determined first. To determine the length of time a person has been covered under a Plan, two Plans are treated as one if the person was eligible under the second within 24 hours after the first ended. The start of a new Plan does not include: a) a change in the amount or scope of a Plan's benefits; b) a change in the entity which pays, provides or administers Plan benefits; or c) a change from one type of Plan to another. The length of time a person is covered under a Plan is measured from his first date of coverage under the Plan. If that date is not available, the date he first became a member of the group will be used.

PROCEDURE FOR SECONDARY PLAN: When a Plan has been determined to be secondary, benefits may be reduced as follows:

1. When one of the plans has contracted for discounted provider fees, the secondary plan may limit payment to any co-payments and deductibles owed by the insured after payment by the primary plan; or
2. If none of the plans have contracted for discounted provider fees, the secondary plan may reduce its benefits so that total benefits paid or provided by all plans for a covered service are not more than the highest allowable expense of any of the plans for that service.
3. The Secondary Plan must calculate the amount of benefits it would normally pay in the absence of coordination and apply the payable amount to unpaid covered charges owed by the insured member after benefits have been paid by the primary plan. A Secondary Plan can use its own deductibles, coinsurance and co-pays to figure the amount it would have paid in the absence of coordination, and a Secondary Plan is not required to pay a higher amount than what they would have paid in the absence of coordination.

A Secondary Plan shall only apply its own deductibles, coinsurance and co-pays to the total allowable expenses, not to the amount left owing after payment by any primary plans.

A Secondary Plan is not required to pay for a service not covered as a benefit under its Plan.

EXCESS PROVISIONS: This Plan complies with order of benefit determination rules established by the State and is a "complying plan". As a complying plan it may coordinate its benefits with a Plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those of this Plan on the following basis:

1. If this Plan is the Primary Plan, it pays its benefits first;
2. If this Plan is the Secondary Plan, it pays its benefits first but the amount paid will be determined as if this Plan were the Secondary Plan, limited to this Plan's liability; and
3. If the Plan that does not comply does not provide the information needed for this Plan to determine its benefits within a reasonable time after requested to do so, this Plan will assume that the benefits of that Plan are identical to this Plan. This Plan will pay benefits accordingly. This Plan will adjust payments made based on such assumption whenever the information becomes available as to the actual benefits of the other Plan.

If the other Plan reduces its benefits so that the Insured receives less than he would have received had this Plan paid benefits as the Secondary Plan and that Plan paid its benefits as the Primary Plan and the Subrogation provision of this Plan applies, then this Plan will advance to or on behalf of the Insured an amount equal to the difference.

In no event will this Plan advance more than would have been paid had this Plan been the Primary Plan, less any amount previously paid under this Plan. In consideration of this advance, this Plan will be subrogated to all rights of the Insured against the other Plan.

FACILITY OF PAYMENT: A payment made under another Plan may include an amount which should have been paid under this Plan. If it does, We may pay the amount to the organization which made that payment in order to satisfy the intent of this COB provision. That amount will then be treated as though it were a benefit paid under this Plan. To the extent such payment is made, We are fully discharged from liability under this Plan. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits in the form of services.

RIGHT OF RECOVERY: If the amount of the payments made by Us is more than the amount necessary at that time to satisfy the intent of this COB provision, We may recover the excess from one or more of: a) the persons We have paid or for whom We have paid benefits; b) insurance companies; or c) other organizations. The "amount of the payments made" includes the reasonable cash value of the benefits in the form of services.

MAXIMUM BENEFITS: This Plan, whether a Primary or Secondary Plan, will never pay a greater total benefit than would have been paid had there been no other Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION: Certain facts are needed to apply COB rules. We have the right to decide what facts We need such as divorce decrees or court documents. We may release to or obtain from any insurance company or other organization or person any needed facts without the consent of any person. Each person claiming benefits under this Plan must furnish Us any facts We need to apply these COB rules.

GENERAL PROVISIONS

OUR RIGHT TO CONTEST: After the Policy has been in force for two years, We do not have the right to contest its various provisions except for non-payment of premiums. After coverage for the insured person has been in force for two years during the insured person's lifetime, We do not have the right to contest the insured person's coverage except for fraud or non-payment of premium.

PAYMENT OF CLAIMS: If the Policy provides coverage of a claimant as a dependent of a parent who has legal responsibility for the dependent's medical care, and such parent does not have custody of the dependent, We may, upon request of the custodial parent, make the payments directly to the provider of care. Any payments so made will release Us from all further liability to the Insured to the extent of the payments made. However, We have the right to pay all or part of the benefits due to the provider of care. This is true whether or not the Insured is alive. If the Insured has died and We do not pay accrued benefits to the provider of care, benefits will be paid to the Insured's estate.

CLAIMANT COOPERATION PROVISION: Failure of a claimant to cooperate with the Us in the administration of a claim may result in the termination of a claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

PROOF OF LOSS AND FILING LIMIT: Written proof of loss must be submitted to Us if You are seeking payment or reimbursement for covered services. Claims must be submitted to Us within 365 days from date of service. If it cannot be provided within that time, it should be sent as soon as reasonably possible. When filing Proof of Loss outside of this timeframe, You must include the reasons for the delay.

TIME OF PAYMENT OF CLAIM: We will pay immediately, or within 30 days following receipt of due written proof of loss, all benefits due under the Policy. If You are not living and We have not paid the provider of care, benefits will be paid to Your estate.

YOUR RIGHT TO APPEAL: If Your claim, or any portion of Your claim, has been denied, You may file a written appeal with Us within 180 days after receiving the written denial. You should provide any additional information or documentation not available when the original claim was filed or reviewed by Us, as well as a statement as to why the claim should be paid. We will, within 60 days, make a full and fair review of the decision to deny benefits and notify You in writing of the decision. Our decision is final and binding on the Plan and claimant.

LEGAL ACTIONS: We may not be sued on a health claim before 60 days after proof of loss has been given to Us. We may not be sued after 3 years (5 years in Kansas; 6 years in South Carolina) from the time proof of loss is required unless the law in the area where You live allows a longer period of time.

PHYSICAL EXAMINATION: We have the right to examine the person whose injury or sickness is the basis of claim as often as We may reasonably require during the pendency of a claim.

CONFORMITY WITH STATE LAW: If any provision of the Policy or Certificate is in conflict with the laws in the state where it is issued it is amended to conform to the minimum requirements of such laws.

FRAUD WARNING: Any person who knowingly, and with intent to defraud or deceive Us or any other person, makes a Request for Insurance or any claim for the proceeds of the Policy containing any false, incomplete or misleading information may be guilty of a crime. In New York, any person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

RIGHT OF REFUND

WHEN THIS PROVISION APPLIES: An insured person may incur charges due to injuries for which benefits are paid by the Policy. The injuries may be caused by the act or omission of another person. If so, the insured person may have a claim against that other person for payment of dental charges. If recovery under the claim is made, the insured person must repay Us the recovery made from: (a) the other person; or (b) the other person's insurer.

AMOUNT SUBJECT TO REFUND: Only the amount recovered for charges incurred will be subject to refund. One-third of the net recovery will be deemed to be for such charges. However, in no case will the amount of refund exceed the amount of benefits paid for the injury under the Policy.

DEFINED TERMS: "Recovery" means monies paid to the insured person through judgment, settlement or otherwise to compensate for all losses caused by the injuries. "Net Recovery" means the insured person's recovery less attorney's fees and court costs incurred in making the recovery. "Refund" means repayment to Us for benefits paid.

RECOVERY FROM ANOTHER INSURER OF THE INSURED: This right of refund also applies when an insured person recovers under an uninsured or underinsured motorist plan.

MINNESOTA GROUP DENTAL INSURANCE PLAN SCHEDULE OF BENEFITS

MAXIMUM ROLLOVER PROVISION:

**** Maximum Rollover Provision Only Included if so Indicated on Summary of Benefits. (Does not apply to orthodontic maximum.)***

This provision gradually increases the amount of the Insured's annual maximum each consecutive year of coverage under the Policy until such time as the annual maximum reaches two thousand dollars. Increases to the annual maximum are automatically applied each year on the anniversary of Your effective date on this Policy. The amount by which the Insured's annual maximum is increased in any given year is determined by the initial annual maximum established by Your employer at the time of Your enrollment on the Policy.

The Insured's annual maximum is increased by $100.00 on the first anniversary of Your effective date; on the second anniversary of Your effective date, the Insured's annual maximum is increased by $200.00; on the third anniversary of Your effective date, the Insured's annual maximum is increased by $300.00; and so forth, with the yearly increase amount applied to the Insured's annual maximum increasing by an additional $100.00 each year, ***until such time as the Insured's annual maximum reaches $2,000.00 at which point no further increases are applied***. **Upon the Insured's annual maximum reaching $2,000.00 (whether this occurs on the first, second, or any subsequent anniversary of coverage under the Policy), no further increases will be applied to the Insured's annual maximum.**

Here are two examples. Your increase will be calculated based on the initial annual maximum shown in the Summary of Benefits:

Example I. If Your initial annual maximum is $1,250.00:	**Example II. If Your initial annual maximum is $1,700.00:**
Year 1: Annual Maximum = $1,250.00 Year 2: Annual Maximum = $1,350.00 Year 3: Annual Maximum = $1,550.00 Year 4: Annual Maximum = $1,850.00 Year 5: Annual Maximum = $2,000.00 Beyond Year 5: Annual Maximum = $2,000.00	Year 1: Annual Maximum = $1,700.00 Year 2: Annual Maximum = $1,800.00 Year 3: Annual Maximum = $2,000.00 Beyond Year 3: Annual Maximum = $2,000.00

Network General Dentist Services:

- **Minnesota** – Premier Network General Dentists accept the Premier fee schedule as payment in full.
- **California** – First Dental Health Network General Dentists accept the First Dental Health fee schedule as payment in full.
- **Nevada** – Diversified Network General Dentists accept the Diversified fee schedule as payment in full.
- **Texas** – *Two provider networks are used in Texas, the Dental Select Network and the Connection Dental Network.* Dental Select Network General Dentists accept the Platinum fee schedule as payment in full. Connection Dental Network General Dentists accept the Connection Dental fee schedule as payment in full.
- **Utah** – Dental Select Network General Dentists accept the Dental Select Platinum fee schedule as payment in full.
- **All other states** – Connection Dental Network General Dentists accept the Connection Dental fee schedule as payment in full.

Network Specialist Services:

- **Minnesota** – Premier Network Specialists accept the Premier fee schedule as payment in full.
- **California** – First Dental Health Network Specialists accept the First Dental Health fee schedule as payment in full.
- **Nevada** – Diversified Network Specialists accept the Diversified fee schedule as payment in full.
- **Texas** – *Two provider networks are used in Texas, the Dental Select Network and the Connection Dental Network. Please note that the method of reimbursement for Specialists varies between the two Networks.*
  Dental Select Network Specialists, Texas – Services rendered will be reimbursed as follows:
  1. The Insured receives a negotiated discount from the specialist's usual fees for eligible services.
  2. After the deductible, We pay Dental Select Network Specialists according to the Dental Select Platinum contracted fee schedule or R&C (method of payment shown in the Summary of Benefits).
  3. The Insured is responsible for the difference between the discounted fee and Our payment.

  Connection Dental Network Specialists, Texas – Connection Dental Network Specialists accept the Connection Dental fee schedule as payment in full.
- **Utah** – Services rendered by a Dental Select Network Specialist will be reimbursed as follows:
  1. The Insured receives a negotiated discount from the specialist's usual fees for eligible services.
  2. After the deductible, We pay Dental Select Network Specialists according to the Dental Select Platinum contracted fee schedule or R&C (method of payment shown in the summary of benefits).
  3. The Insured is responsible for the difference between the discounted fee and Our payment.
- **All other states** – Connection Dental Network Specialists accept the Connection Dental fee schedule as payment in full.

Fee Schedules are subject to change upon notification.

If full payment of the co-payment is not made to the provider within 90 days, the provider may bill You his/her standard fees.

Use of a Network provider does not guarantee that all charges will be covered under the Policy. All charges are subject to all terms and conditions of the Policy.

Non-Network Provider Services – Non-Network Provider services will be paid based on the contracted fee schedule or R&C (method of payment shown in the Summary of Benefits). Charges above the Plan Payment are the Insured's responsibility.

COVERED SERVICES:

The following is the list of Covered Services for which benefits are payable under the policy. Procedures not listed below are not covered or, may be covered at Our sole option if such procedures are considered to be appropriate and are performed according to accepted standards of dental practice for the condition. All services are subject to review for necessity; X-rays, charting, and/or records may be required to determine if any procedure is covered.

Class A. Preventive Services Include: ***May be subject to a waiting period. Refer to Summary of Benefits.***

1. routine examinations and cleaning – 2 per year (in conjunction with all other exams);
2. topical fluoride *(age 18 & under)* – 1 per 12 months;
3. bitewings x-rays *(age 11 & over)* – 8 total per 12 months;
4. periapical x-rays;
5. occlusal x-ray – 1 upper and 1 lower per 24 months.

Class B. Basic Services Include: ***May be subject to a waiting period. Refer to Summary of Benefits.***

1. non-routine exams and consultations - 2 per year (in conjunction with all other exams);
2. fillings of amalgam, silicate, acrylic, synthetic porcelain and composite filling materials – once per tooth surface per 24 months (benefits for composite (white) fillings on posterior (back) teeth shall be limited to the same surfaces and allowances for amalgam (silver) fillings; the patient is responsible for the difference in cost between the plan payment and the dentist's submitted fee.);
3. pin retention of fillings;
4. space maintainers (*age 16 & under)* – once per lifetime (to preserve space between teeth for premature loss of a primary baby tooth. **This does not include use for orthodontic treatment**);
5. sealants on permanent first and second molars *(age 14 & under)* – once per 36 months*;*
6. stainless steel or pre-fabricated crowns *(age 18 & under)* – once per lifetime;
7. general anesthesia, including intravenous sedation:
    - age 7 & under – 1 per 12 months, up to $150;
    - age 8 & over – for the extraction of impacted teeth, based on necessity and not for anxiety management, up to $150 per year.

Class C. Major Services Include: ***May be subject to a waiting period. Refer to Summary of Benefits.***

1. panoramic* *(age 6 & over)* or full mouth series* x-rays *(age 11 & over)* – 1 per 60 months;
2. periodontic services* *(only 1 complex surgical periodontal service is a benefit covered 1 time per 36 month period per single tooth or multiple teeth in the same quadrant):*
    - perio maintenance - 2 per year (in lieu of preventive cleaning);
    - root scaling and planing (once per quadrant of mouth in any 36 month period);
    - gingivectomy, gingival curettage;
    - osseous surgery including flap entry and closure;
    - pedical or free soft tissue grafts;
    - full mouth debridement - once per lifetime (limited services available on same date of service);
3. endodontic treatment*: root canal therapy *(age restrictions may apply)*; pulpotomy; pulpal therapy (**excludes** retreatment of endodontic services that have been previously benefited under the Plan; removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root); root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth; intentional reimplantation, apicoectomy; root amputation, apexification; retrograde filling; hemisection);
4. crowns, onlays – once per 60 month period per tooth *(age restrictions may apply)* (**excludes** crown build-up, posts and pins);
5. inlays – (benefit shall equal an amalgam (silver) restoration for the same number of surfaces. If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Plan's payment for the covered benefit and the dentist's submitted fee, plus any coinsurance for the covered benefit).
6. recementing inlays, crowns and bridges;
7. dentures, partials, bridges *(age 16 & over)* – once per 60 months*;*
8. repair of dentures or bridges – 1 per 6 months;
9. adjustments of dentures, partials or bridge – 1 per 12 months;
10. relining or rebasing of existing removable dentures – 1 per 24 months;
11. implants, supported fixed and removable prosthetic (crowns, bridges, partials, dentures) – a restoration that is retained, supported and stabilized by an implant – (This procedure receives and optional treatment benefit equal to the least expensive professionally acceptable treatment. The additional fee is the patient's responsibility);
12. oral surgery – simple extraction of teeth; frenectomy, incision and drainage of intraoral abscess; extraction of impacted teeth; surgical exposure of teeth; alveolectomy; alveoplasty; excision of pericoronal gingiva, exostosis, hyperplastic tissue; reimplantation and repositioning of natural tooth;
13. occlusal guards for bruxism only – 1 per 24 months.

Panoramic or full mouth series x-rays may be covered under Preventive Services. Refer to Summary of Benefits.
Periodontic and Endodontic services may be covered under Basic Services. Refer to Summary of Benefits.

Class D. Orthodontia Services: ***May be subject to a waiting period. Refer to Summary of Benefits.***

***Orthodontia Services Only Included if Indicated on Summary of Benefits.**

1. appliance therapy
    a. diagnostic records – (cephalometric film, panoramic or full mouth x-rays, diagnostic casts, diagnostic photographs.)
    b. removable, fixed or cemented appliance for orthodontic treatment including impressions, installations, & adjustments while covered under the plan.

No coverage or limited coverage for orthodontic treatment which began prior to the effective date of coverage.

MANDATED COVERAGE PROVISION – Minnesota Residents Only

A. Benefits will be paid for dental treatment up to the limiting age for coverage of Dependents, including orthodontic and oral surgery treatment, involved in the management of birth defects know as cleft lip and cleft palate. Benefits for individuals age 19 up to the limiting age for coverage of the Dependent are limited to inpatient or outpatient expenses arising from dental treatment that was scheduled or initiated prior to the Dependent turning age 19. If orthodontic services are eligible for coverage under this policy and another policy or contract, this policy shall be primary and the other policy or contract shall be secondary in regard to the coverage required for Dependents under the age of 19. Payment for dental or orthodontic treatment not related to the management of the congenital conditions of cleft lip and cleft palate are not covered under this provision.

B. Benefits will be paid for surgical and non-surgical dental treatment of TMJ (temporomandibular joint). Coverage will be provided at the highest percentage level, and in the same manner, as that paid for the treatment of any major dental procedures that are covered by this policy. Other major dental procedures may include treatment for crowns, root canals, bridges, dentures, or orthodontic treatment and shall apply if the treatment is administered or prescribed by a physician or a dentist.

NOTE: If you or your dependents currently have medical insurance coverage, the claim must be first submitted to that medical insurance program. Any remaining costs after consideration under your medical insurance may be submitted to the Plan for further benefit (see Coordination of Benefits). You must submit a copy of the medical Explanation of Benefits (EOB) along with your claim to this Plan.

If you or your dependents are not eligible for TMJ benefits under another insurance program, either medical or dental, dental services for TMJ will be covered under this dental Plan within the noted Plan limitations, maximums, deductibles and payment percentages of treatment costs.

EXPENSES NOT COVERED: No benefits will be paid for expenses incurred:

1. for services and supplies not listed in the Summary of Benefits, not recognized as essential for the treatment of the condition according to accepted standards of practice or considered experimental.
2. for cosmetic procedures, including but not limited to veneers and bleaching of teeth and procedures performed primarily for cosmetic reasons.
3. for services related to, performed in conjunction with, or resulting from a non-covered procedure.
4. for charges in excess of the contracted Fee-for-Service schedule or the Usual and Customary rate, whichever applies.
5. for any treatment program which began prior to the date the Insured is covered under the Policy.
6. for crowns, inlays and onlays on teeth that can be restored by direct placement materials.
7. for the replacement of crowns, bridges, inlays, onlays or prosthetic appliance within 5 years from the date of last placement.
8. for service or supplies payable under any medical expense, auto or no-fault plan.
9. for any condition covered under any Worker's Compensation Act or similar law.
10. for services applied without cost by any municipality, county or other political subdivision or for which there would be no charge in the absence of insurance.
11. for services that are applied toward the satisfaction of a Deductible, if any.
12. for services subject to a waiting period.
13. for charges resulting from changing from one provider to another while receiving treatment, or from receiving treatment from more than one provider for one dental procedure to the extent that the total charges billed exceed the amount incurred if one provider had performed all services.
14. for hospital facility charges for any dental procedure, including but not limited to: emergency room charges, surgical facility charges, hospital confinement.
15. for drugs or the dispensing of drugs.
16. for oral hygiene instruction; plaque control; acid etch; prescription or take-home fluoride; broken appointments; completion of a claim form; OSHA/Sterilization fees (Occupational Safety & Health Agency); or diagnostic photographs (except for orthodontic purposes).
17. for myofunctional therapy; athletic mouth guards; precision or semi-precision attachments; treatment of fractures, cysts, tumors, or lesions; maxillofacial prosthesis; orthognathic surgery; or anodontia.
18. for orthodontia, unless included within the Summary of Benefits.
19. for services to replace teeth that were missing or extracted prior to the effective date of coverage on Our Plan. This limitation ends after 24 months of continuous coverage under this Plan.
20. for composite, resin, or white fillings on posterior teeth. Benefit will be reduced to that of an amalgam or silver filling unless otherwise specified in the Summary of Benefits.
21. for the replacement of a filling within 24 months of placement, unless for specific health reasons.
22. for the replacement of retainers.
23. for sealants not applied to permanent first or second molars, applied at age 15 or older; applied less than 3 years from a previous sealant application; applied to a decayed tooth.
24. for lab fees for higher metals or porcelain crowns, bridges, inlays or onlays.
25. during travel or activity outside the United States.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit Us from providing insurance including, but not limited to, the payment of claims.

HIPAA Privacy Notice

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.

ACE USA and Dental Select value their relationship with you. Protecting the privacy of information we have about you is of great importance to us. We want you to understand how we protect the confidentiality of that information as well as how and why we use and disclose it. We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to this information. "Protected health information" includes any individually identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your healthcare.

The following provides details of our practices and procedures for protecting the security of nonpublic personal information both while you are our customer and when you are no longer our customer. This privacy policy applies to dental care policies administered by Dental Select and underwritten by ACE American Insurance Company or ACE Insurance Company of Texas. We are required to comply with the terms of this notice. If you receive a copy of this notice electronically you may obtain a copy upon written request. We reserve the right to change the terms of this notice, and should that occur, we will provide you with a copy of the new notice.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

In order to provide you with insurance coverage, we need personal health information about you, and we obtain that information from many different sources –particularly your plan sponsor, other insurers, HMOs or Third Party Administrators (TPAs), and health care providers. In administering your benefits, we may use and disclose this information in various ways.

Your Authorization
Except as outlined below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing; however your revocation will not affect any use or disclosure permitted while your authorization was in effect.

Uses and Disclosures for Payment
We may use and disclose your personal health information as necessary for payment purposes. For instance, we may use and disclose information regarding your medical care to process and pay claims.

Uses and Disclosures for Treatment
While we don't provide treatment, we might share protected health information to assist your provider in supplying treatment to you.

Uses and Disclosures for Health Care Operations
We may use and disclose your personal health information as necessary, and as permitted by law, for our health care operations such as customer service, premium rating, fraud and abuse prevention and detection, and other functions related to your dental plan. We may use and disclose your personal health information to provide you with information about treatment alternatives or other benefits and services that may be of interest to you.

Family, Friends, and Others Involved In Your Care
With your approval, we may disclose your personal health information to designated family, friends, and others, to assist that person in caring for you or in paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with such individuals without your approval.

Business Associates
At times it may be necessary for us to provide some personal health information to one or more outside persons or organizations who assist us with our business activities. We require these business associates to appropriately safeguard the privacy of your information.

Additional Uses and Disclosures Without Your Authorization
We are permitted or required by law to make certain other uses and disclosures of your personal health information without your authorization, including under the following conditions:

- to the plan sponsor for use in administration of the insurance plan;
- for any purpose as required by law;
- for public health activities, such as required reporting of certain diseases;
- as required by law if we suspect child abuse or neglect; we may also release your personal health information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence;
- if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings; or if required to do so by a court or administrative ordered subpoena, discovery request, or qualified protective order; to law enforcement officials as required by law;
- to coroners and/or funeral directors consistent with law;
- if necessary to arrange an organ or tissue donation from you or a transplant for you;
- if you are a member of the military as required by armed forces services; we may also release your personal health information if necessary for national security or intelligence activities;
- if necessary to avert a serious threat to health or safety; or,
- to Workers Compensation agencies if necessary for your workers compensation benefit determination.

YOUR HIPAA PRIVACY RIGHTS

Access to Your Personal Health Information
You have the right to obtain a copy and inspect specific items of your personal health information, such as your policy or claim information, for as long as we maintain it. We may deny your request to access certain personal health information, as permitted or required by law. We may require your request for access in writing. Your request for access should contain as much detail as possible regarding the personal health information you wish to review. We may charge a reasonable fee for access to your personal health information.

Amendments to Your Personal Health Information
You have the right to request an amendment of the personal health information we maintain about you if you believe it is incorrect. We are not legally obligated to make all requested amendments but will give each request appropriate consideration. Requests for amendment must be in writing and must state the reasons for the amendment request.

Accounting for Disclosures of Your Personal Health Information
You have the right to request a list or accounting of certain disclosures of your personal health information. We are not legally obligated to provide an accounting of every disclosure but will give each request appropriate consideration. Requests must be made in writing. The accounting will not include disclosures made prior to April 14, 2003.

Restrictions on Uses and Disclosures of Your Personal Health Information
You have the right to request restrictions on certain uses and disclosures of your personal health information for treatment, payment, or health care operations by notifying us of your request for a restriction in writing. We are not legally required to agree to your restriction request.

Confidential Communication of Personal Health Information
You have the right to request to receive communications from us regarding your personal health information by another method of contact or at an alternative address. We will accommodate reasonable requests, which must clearly state that disclosure of all or part of the information could endanger your health or safety.

Complaints
If you believe your privacy rights have been violated, you can file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. There will be no retaliation for filing a complaint.

How To Contact Us
If you have questions or need further assistance regarding this Notice, or wish to exercise any of the above-mentioned rights, you may write to us at ACE INA Customer Services, P.O. Box 1000, 436 Walnut Street, WA04F, Philadelphia, PA 19106 or call 215-640-2611. You may contact Dental Select directly at: Dental Select, Attn: Compliance Officer, 5373 S. Green Street, 4th Floor, Salt Lake City, UT 84123 or call 801-495-3000 or 800-999-9789. Please include your name, address, plan sponsor, and policy number in any correspondence.

Effective February 2008