



ACE American Insurance Company
Philadelphia, PA 19106

ACE USA (herein called We, Our or Us) certifies that the Insureds listed on the Certificate below are covered under the Policy issued to the Policyholder.

**YOUR INSURANCE CERTIFICATE
GENERAL INFORMATION
About Your Insurance**

This Certificate explains the plan of insurance underwritten by ACE USA. 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.

A stylized, handwritten signature in black ink, appearing to read 'J. Lupica'.

JOHN J. LUPICA, President

A handwritten signature in black ink, appearing to read 'George D. Mulligan'.

GEORGE D. MULLIGAN, Secretary

DENTAL INSURANCE CERTIFICATE

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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.

CONTRACTING 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.

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.

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 dependent on the Insured for federal income tax purposes at the time application for coverage of the child is made.

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: 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.

NON-CONTRACTING 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 AND CUSTOMARY (R&C): means the reasonable and customary charges for the area where such expenses are incurred.

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

WAITING PERIOD: 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. A notice of birth together with the premium must be submitted to Us. This must be done within 31 days after the date of birth. Coverage for Dependent children includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities or prematurity.

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.

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 (contact your employer for any Voluntary Continuation option);
2. the last day Your Dependent ceases to be a Dependent, as defined;
3. last day of the month for which a premium has been paid; or
4. date the Policy ends.

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.

VOLUNTARY TERMINATION: If You voluntarily end Your insurance without a qualifying event and re-enroll at a later date, Your re-enrollment waiting period is 2 years and begins on the date Your coverage first ended.

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.

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 Summary of Benefits.

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 CALENDAR/CONTRACT YEAR LIMIT: The maximum limit payable for all Eligible Expenses in any calendar/contract year is shown in the Summary of Benefits. 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 Summary of Benefits. The Deductible is an amount of charges You must incur for Yourself or on behalf of Your insured Dependent before We start paying benefits.

CONTRACTING GENERAL DENTIST SERVICES: Contracting 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 Contracting 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.

CONTRACTING 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.

Contracting Specialists have agreed to provide services at a discount from their usual fees (Utah/Texas only). The discounted rate is based on the negotiated agreement in the provider's contract. Services rendered by a Contracting Specialist outside of Utah/Texas will be reimbursed as stated in the Specialist Schedule.

Use of a Contracting 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-CONTRACTING GENERAL DENTIST & SPECIALIST SERVICES: Non-Contracting Dentists and Specialists do not accept Our contracted fee schedule as payment in full. Services will be reimbursed as stated in the Summary of Benefits. 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.

COORDINATION OF BENEFITS

COORDINATION of BENEFITS (COB) and 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 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 paragraph 2 (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. Benefits for other losses are paid to the Insured. 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.

The policy will pay benefits of a Dependent child to a person who is not covered under the Policy if the following conditions are met:

1. a certified copy of the court order providing for the managing or possessory conservator of the child issued by a court of competent jurisdiction in Texas or any other state is submitted to Us.
2. a written notice that the person is the managing or possessory conservator of the child is submitted to Us.

We are required to pay benefits to The Texas Department of Human Services in certain situations shown below. In these situations, this method of benefit payment replaces any description of benefit payment shown in the Policy.

All benefits paid on behalf of a Dependent child must be paid directly to The Texas Department of Human Services under the following conditions:

1. The Texas Department of Human Services is paying the benefits for the Dependent child; and
2. the Covered Person has legal custody of the Dependent child or the Covered Person does not have legal custody of the Dependent child but is required to pay child support.

A notice must be attached to our claim department form to the claim form and submit both forms to Us. Payment will be made to The Texas Department of Human Services if it has paid for any covered expenses through Medicaid.

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. Claims submitted after 365 days from date of service will be denied. Adjustments or corrections to claims are denied if submitted more than one year after the claim was processed.

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 60 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.

PLATINUM/SIGNATURE GROUP SCHEDULE OF BENEFITS DENTAL INSURANCE PLAN - TEXAS

MAXIMUM ROLLOVER PROVISION: This provision raises the maximum allowed per benefit period in graduated levels on the anniversary of the subscriber's MAX plan effective date. Your annual maximum levels are as follows (*does not apply to orthodontic maximum*):

- 1st Year - \$1,000
- 2nd Year - \$1,100
- 3rd Year - \$1,300
- 4th Year - \$1,600
- 5th Year - \$2,000

Contracting General Dentist Services:

Two provider networks are utilized in Texas, the Dental Select Network and the Connection Dental Network.

- **Texas** – Dental Select Participating General Dentists accept the Platinum or Traditional fee schedule as payment in full & Connection Dental Participating General Dentists accept the Connection Dental fee schedule as payment in full.
- **Utah** – Dental Select Participating General Dentists accept the Platinum or Signature fee schedule as payment in full.
- **Nevada** – Diversified Participating General Dentists accept the Diversified fee schedule as payment in full.
- **All other states** – Connection Dental Participating General Dentists accept the Connection Dental fee schedule as payment in full.

Contracting Specialist Services:

Two provider networks are utilized 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.

- **Texas** – Services rendered by a **Dental Select Participating 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 Participating Specialists according to the Dental Select Platinum or Signature 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.
- **Texas** – Services rendered by a **Connection Dental Participating Specialist** will be reimbursed according to the Connection Dental fee schedule as payment in full.
- **Utah** – Services rendered by a **Dental Select Participating 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 Participating Specialists according to the Dental Select Platinum or Signature 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.
- **Nevada** – Diversified Participating Specialists are contracted to the Diversified Specialist fee schedule as payment in full.

- **All other states** – Connection Dental Participating Specialists are contracted to the Connection Dental fee schedule as payment in full.

Non-Contracting Provider Services – Non-contracting services will be paid based on the reasonable and customary charges for the area. Charges above the reasonable and customary are the member's responsibility.

Use of a Contracting 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. Services not listed on the Provider Fee Schedules are available on a fee-for-service basis and are the patient's full responsibility.

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

Fee Schedules are subject to change January 1 of each year.

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 the sole option of ACE American Insurance Company 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 cleanings; topical fluoride (*age 14 & under*) – 2 per year (in conjunction with all other exams);
2. panoramic (*age 6 and over*) or full mouth series x-rays – 1 every 36 months;
3. bitewings x-rays – 8 total per year (*age 11 and over*);
4. periapical x-rays;
5. occlusal x-ray – 1 upper and 1 lower every 24 months.

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

1. 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;
2. non-routine exams and consultations - 2 per year (in conjunction with all other exams);
3. fillings of amalgam, silicate, acrylic, synthetic porcelain and composite filling materials;
4. pin retention of fillings;
5. space maintainers (*age 14 and under*) - to preserve space between teeth for premature loss of a primary baby tooth. **This does not include use for orthodontic treatment;**
6. sealants on permanent bicuspid and molars – every 36 months (*age 14 and under*).
7. endodontic treatment*: root canal therapy (*age restrictions apply*); pulpotomy; pulpal therapy; apicoectomy; apexification/recalcification; root amputation; hemisection; intentional reimplantation; retrograde fillings.

*Endodontic treatment may be covered under Major depending on the Group, refer to your Summary of Benefits.

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

1. periodontic services*:
 - perio maintenance - 2 per calendar year (in lieu of preventive cleaning);
 - root scaling and planing (once per quadrant of mouth in any 24 month period);
 - gingivectomy, gingival curettage;
 - osseous surgery including flap entry and closure;
 - pedical or free soft tissue grafts;
 - full mouth debridement - 1 per lifetime;
2. crown build-up; post and core;
3. recementing inlays, crowns and bridges;
4. repair of dentures or bridges;
5. general anesthesia, including intravenous sedation (subject to 6 month waiting period):
 - age 7 & under - once per calendar year, 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;
6. crowns, bridges, inlays, onlays, dentures and gold fillings- every five years. (Additional lab fee may be charged by provider for higher metals and porcelain that is not covered by the plan.);
7. addition of teeth to existing partial denture;
8. relining or rebasing of existing removable dentures- 1 per year;
9. occlusal guards for bruxism only – 1 every 2 years;
10. stainless steel crowns- 1 every 2 years.

*Periodontic services may be covered under Basic depending on the Group, refer to your 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.

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 Reasonable 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 implants; myofunctional therapy; athletic mouthguards; precision or semi-precision attachments; treatment of fractures, cysts, tumors, or lesions; maxillofacial prosthesis; orthognathic surgery; TMJ dysfunction; cleft palate; or anodontia.
18. for orthodontia, unless included within the Summary of Benefits.
19. for services to replace teeth that were missing (extracted or congenitally) prior to the effective date of coverage on Our Plan. This limitation ends after 36 months of continuous coverage on the Plan. Abutment teeth will be reviewed for eligibility of prosthetic benefits. This exclusion does not apply if the device covers one or more natural teeth lost or extracted while covered under the Plan, or if the prosthetic device was in place when the policy became effective.
20. for composite, resin, or white fillings on posterior primary teeth. Benefit will be reduced to that of an amalgam or silver filling.
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 bicuspid or molar; applied at age 15 or older; applied 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, Suite 400, 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