Dental Select Administrative Guide

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General Information

This guide is designed to assist you with the administration of your group plan(s) purchased from Dental Select. In the unlikely event a discrepancy exists between this guide and the terms of the policy or certificate of insurance, the policy and certificate will govern.

All insurance products are fully insured by ACE American Insurance Company and administered by Dental Select.

Contact Us

If you have any questions or need additional information about your benefit plans, please contact us and we will be happy to provide you with personal assistance.

Dental Select Corporate Headquarters

5373 S. Green Street, 4th Floor
Salt Lake City, UT 84123
Tel (800) 999-9789 or (801) 495-3000
Fax (888) 673-5328 or (801) 495-3368
www.dentalselect.com

Service Requests & Membership Changes

By Mail:
Attn: Eligibility Department
Dental Select
5373 S Green Street, 4th Floor
Salt Lake City, UT 84123

By Fax:
888-998-8704 / 801-290-5101

By Secure Email:
Eligibility_web@dentalselect.com

Enrollment Guidelines

Eligible employees and their dependents may enroll for coverage during Open Enrollment or upon experiencing a Qualifying Event. Refer to the Forms Guide (pg. 9) for the proper form to use when enrolling employees and their family members for coverage.

Open Enrollment
Open Enrollment is the 31 days immediately following your group's renewal date. Eligible employees and dependents who previously declined coverage can choose to enroll during this period. Employees can also choose to add/ delete dependents or change plans during this period, if more than one plan is being offered.

New Hire Waiting Period
A New Hire Waiting Period is the required period of full-time employment a new hire must complete before applying for coverage under the plan. The length of your company's New Hire Waiting Period can vary. The New Hire Waiting Period is established at the time of your group's application for coverage and agreed to by Dental Select.

Eligible Employees & Dependents
Full-time employees and their dependents are eligible for coverage on the later of: (1) the policy effective date, or (2) the day after the employee completes the New Hire Waiting Period. Generally speaking, a full-time employee is one who works at least 30 hours per week and is on the regular payroll of the employer. (Your company's definition of full-time employment may differ.) Independent contractors, temporary or seasonal workers, and part-time employees are not eligible for coverage.

Persons eligible for dependent coverage are defined in your certificate of insurance. An eligible dependent is typically the insured employee's lawful spouse or unmarried child (up to the dependent age limit, as defined under State law). Dependents may also include domestic partners, or any person related to the insured employee by blood or marriage and for whom the insured is allowed a deduction under the Internal Revenue Code.

Unmarried children who are enrolled for coverage prior to reaching the dependent age limit may continue coverage if they meet all of the following conditions: (1) the child is handicapped, (2) the child is not capable of self-support, and (3) the child depends mainly on the insured employee for support and maintenance. We may ask for proof that the child meets these conditions.

New Hire Enrollment & Coverage Effective Date
New hires and their dependents may enroll for coverage within 31 days of becoming eligible, in accordance with your company's New Hire Waiting Period. Coverage is effective on the first of the month following the date the employee completes the New Hire Waiting Period, provided Dental Select timely receives a completed enrollment form.

> ***Helpful Hint:*** *To ensure timely enrollment, we strongly recommend you submit enrollment forms at the time of hire, rather than waiting until your employee has completed the New Hire Waiting Period. Failure to submit completed enrollment forms on a timely basis could result in a delayed coverage effective date.*

Enrolling Employees who Previously Waived or Declined Coverage
Employees who previously waived or declined coverage may enroll during Open Enrollment or within 31 days of a Qualifying Event. A Qualifying Event is:

- Marriage
- Birth/ adoption
- Loss/ gain of other coverage
- Divorce/ legal separation/ annulment
- Death
- Military active duty/ return to civilian position

Provided Dental Select timely receives a completed Enrollment Form, coverage will be effective the 1st of the month following the Qualifying Event.

Requests to add/ cancel employee coverage may be submitted via the Web Portal or on an Employee Change Form. An enrollment request is considered "timely" if received by Dental Select within 31 days of the Qualifying Event.

Enrollment Guidelines (cont.)

Enrolling Re-Hired Employees
A "re-hire" is an employee whose employment was terminated, and subsequently re-hired by the same company within 6 months.

Waiving Benefit Waiting Periods for New Hires
Dental Select will waive benefit waiting periods for basic and major services for the number of months effective with a prior carrier (up to 12 months) when a Letter of Credible Coverage and a Summary of Benefits from the prior carrier are received. These documents must be submitted with the enrollment or within 45 days of the employee's effective date on your Dental Select plan. If this information is not timely received, benefit waiting periods will not be waived. Coverage under the prior plan must not have lapsed for more than 60 days. Other restrictions may apply.

Terminating Employee Coverage

Employee coverage may be terminated due to loss of employment or loss of eligibility or, in certain situations, when an employee voluntarily chooses to drop coverage. ***Refer to the Forms Guide (pg. 9) for the proper form to use when reporting the termination to Dental Select.***

Loss of Employment/ Loss of Eligibility
Employees must be canceled from the plan upon termination of employment or a change in employment status which results in the employee no longer being eligible for coverage (e.g., from full-time to part-time employment). Terminations resulting from loss of employment/ loss of eligibility should be reported to Dental Select on the Employee Change Form. Terminated employees and those no longer eligible for coverage are deleted from the plan on the last day of the month in which the termination notice was received by Dental Select.

Due to COBRA and mini-COBRA requirements, Dental Select must be notified on a timely basis of all employee terminations as they occur. Retroactive terminations by the group are not allowed.

Voluntary Termination with a Qualifying Event
Enrolled employees may terminate coverage during Open Enrollment or within 31 days of a Qualifying Event. For purposes of terminating coverage, a Qualifying Event is:

- Marriage
- Birth/ adoption
- Loss/ gain of other coverage
- Divorce/ legal separation/ annulment
- Death
- Military active duty/ return to civilian position

Provided Dental Select receives a completed Employee Change Form within 31 days of a Qualifying Event, coverage will be terminated the end of the month in which the Qualifying Event occurred.

Voluntary Termination without a Qualifying Event
If an employee voluntarily terminates coverage without a Qualifying Event and wishes to re-enroll at a later date, Dental Select reserves the right to require a two year waiting period. The two-year waiting period begins on the date coverage was first terminated.

> ***Helpful Hint:*** *Terminations must be submitted on an Employee Change Form to be considered valid. Please do not attempt to terminate coverage by making notations on your billing invoice (e.g., crossing out an employee's name, writing "term" next to the employee's name, etc.). Improperly remitted termination requests will not be processed.*

Federal COBRA
COBRA requires employers of 20 or more full-time employees (or its equivalent) to provide a continuation of group health (and dental) coverage under certain circumstances. Under this federal law, the employer is responsible for administering COBRA and complying with all COBRA notice requirements. Dental Select is not responsible for COBRA administration.

Terminating Employee Coverage (cont.)

Federal COBRA (cont.)

COBRA sets rules for how and when continuation coverage must be offered and provided, how employees and their families may elect continuation coverage, and what circumstances justify terminating continuation coverage. If you are unsure of your obligations as an employer under this federal law, please seek advice from your trusted legal or tax advisor, or contact your local IRS office. Dental Select does not provide legal advice or opinions. Information, guides, and model notices are available at www.dol.gov/COBRA.

Please use the Employee Change Form to notify Dental Select when a qualified beneficiary is enrolling for COBRA continuation coverage. Dental Select will reinstate the qualified beneficiary back to their original termination date, without a lapse in coverage.

State Continuation ("mini-COBRA")

If your company has less than 20 employees, you should be aware that many states extend similar access to continuation of group coverage through "mini-COBRA" laws. Under state mini-COBRA laws, the notification periods, election periods, continuation periods, etc., may be different from those required under federal COBRA. If you are unsure of your obligations as an employer under State continuation of coverage laws, please seek advice from your trusted legal or tax advisor, or contact your local Department of Insurance.

Please use the Employee Change Form to notify Dental Select when a qualified beneficiary is enrolling for mini-COBRA (or your State's equivalent) continuation coverage. Dental Select will reinstate the qualified beneficiary back to their original termination date, without a lapse in coverage.

Helpful Hint: *When an employee is terminated or loses eligibility due to a change in employment status, it is the responsibility of the employer to promptly report the termination to Dental Select. If an employee and/ or dependent(s) is eligible to continue coverage through COBRA (or the State's equivalent of mini-COBRA) and enrolls for such coverage within the election period, the employer must notify Dental Select. We will reinstate coverage to the date of termination; there will be no break in coverage.*

EDI (Electronic Data Interchange)

If you administer your group policy using EDI file uploads, all eligibility and enrollment changes should be submitted in your regular EDI file.

Billing and Plan Maintenance

Billing Procedures

The date on which your invoice is generated depends on your payment method and type of contract:

- If your fully-insured group is enrolled for ACH auto-pay, invoices are generated on the 25th of each month and the premium amount due will be drafted within 3 business days of invoice.
- If your fully-insured group is not enrolled for ACH auto-pay, your invoice will be generated on the 15th of each month and payment is due by the 10th of the following month.
- Self-funded group plan accounts are invoiced in accordance with the administrative contract. Administrative charges are typically billed monthly, and invoices for incurred claims are generated as agreed upon by the parties.

All cancellations, additions, or changes received and processed by Dental Select within five days of your invoice date will be reflected on the following month's invoice. It's important to look over each section of your invoice to make sure it's correct. To ensure proper credit, enclose a copy of your statement or write your group number on your check.

Helpful Hint: *It's important to pay your invoice exactly as billed. Do not deduct premium for cancelled employees or add premium for enrolling employees. If your monthly payment results in a shortage, the premium is considered delinquent and your policy is subject to cancellation. Send applications and terminations to Dental Select as soon as they occur to help keep your invoice up to date.*

ID Cards

New membership ID cards are mailed approximately 7 days after Dental Select receives and processes a completed Enrollment Form and/ or Employee Change Form. Certificates of insurance and co-payment schedules (if applicable) are available via the Web Portal. Members should bring their ID card to all dental appointments to ensure the provider is aware of their dental plan and can discount the charges accordingly.

Billing and Plan Maintenance (cont.)

ID Cards (cont.)
Dental Select's mobile ID card app allows members to conveniently access their ID card on their mobile device. Members can view and easily send their ID card directly to any provider or dependent. If an employee loses their ID card, please instruct them to print a new ID card via the Web Portal or use the mobile ID card app (available on iOS and Android devices).

Termination of Group Policy
Should you choose to cancel your group's policy for any reason, please send written notification to Dental Select within thirty (30) days of the requested termination date. If no termination date is specified, termination will be effective on the later of: (1) the 1st of the month following receipt of notice; or (2) the end of the month for which premium has been paid.

Written requests to terminate must be submitted using a Group Change Form or on company letterhead, and signed by an officer of the company. If Dental Select terminates your group policy, it will be effective on the later of: (1) the date stated in the notice; or (2) 10 days after the notice is delivered.

Termination of Group Policy due to Non-Payment
Your group policy may be terminated for failure to pay premium. If the required premium is not paid in full by the end of the grace period stated in your policy, insurance will end on the last day of the period for which premiums were paid.

Termination of Group Policy due to Participation/ Contribution Requirements
Your group's application for insurance outlines participation and contribution requirements for each plan type. Failure to maintain minimum participation or contribution requirements may result in termination of any policy at renewal.

> ***Helpful Hint:*** *It is the company's responsibility to notify its employees of termination of group coverage within the timeframe mandated by law.*

Renewal
Subject to Dental Select's consent, your group policy may be renewed each anniversary date. Dental Select will send a renewal letter to you and your insurance agent approximately 60-90 days prior to your policy's anniversary date. This letter will note the renewal premium and, depending on your current plan and claims history, may present several plan savings options for your consideration.

Web Portal
Visit the Web Portal to add/ cancel an employee, get a copy of your policy or certificate of insurance, print replacement ID cards, enroll a new hire, etc. Go to www.dentalselect.com and click on Web Portal.

Network Access

Several of Dental Select's dental plans offer members the opportunity to save money by using a participating provider – a general dentist or specialist who participates on Dental Select's network.

Dental Select's network offers employees freedom of choice, flexibility, and satisfaction with lower out-of-pocket costs. Employees are not required to name a primary provider or receive a referral to visit a specialist. Employees can go to any dentist or specialist of their choice; the out-of-pocket savings is greatest when receiving care from a participating provider.

Not only does the member receive quality care at a substantial savings, but employers also benefit when employees go in-network, because lower claims costs helps keep premium rates low.

Depending on which dental plan(s) you offer your employees, services received from specialists may or may not be eligible for a benefit payment. Employees should verify their provider of choice participates in the Dental Select network before receiving services, and should closely review their plan documents to best understand their insurance benefits.

For the most up-to-date list of more than 200,000 provider access points (locations of general dentists and specialists who participate in Dental Select's network), visit www.dentalselect.com.

Helpful Hint: *Dental Select strongly recommends that all services over $300 be submitted for pre-determination prior to incurring the expense. Dental Select will provide the dental provider and patient with exact payment amounts so they can make informed decisions about the treatment program prescribed by the provider.*

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Dental Select Forms Guide

Submit completed forms to Dental Select:

By Mail:	By Fax:	By Secure Email:
Attn: Eligibility Department Dental Select 5373 S Green Street, 4th Floor Salt Lake City, UT 84123	888-998-8704 / 801-290-5101	Eligibility_web@dentalselect.com

Action	Form to Use	Instruction
Enroll a new hire (and dependents, if any)	Enrollment Form	Submit at time of hire (prior to effective date).
Enroll a rehire (an employee re-hired within 6 months of termination)		Write "rehire" on form; include termination date and rehire date.
Decline/ waive coverage for a new hire		Indicate whether coverage is declined or waived.
Cancel an employee's coverage due to termination of employment	Employee Change Form	Submit at time of termination.
Cancel employee/ dependent coverage due to a qualifying event		Submit within 31 days of event; additional documentation may be required.
Enroll new dependents of an existing employee		
Enroll employee/ dependent(s) on COBRA/ mini-COBRA		Submit at time of election.
Update employee's name or address		Request can also be made by employee directly, by calling Member Services at 800-999-9789.
Update Company's name or address	Group Change Form	Must be signed by an officer of the company; additional documentation may be required.
Update Company's HR or billing contact person		
Terminate group policy		
Request a New Hire Waiting Period change		
Specific questions regarding an employee's claim	PHI Authorization Form	Employee must give written authorization before any specific claim information or health records will be released.
Request for copies of records		

Forms are available at www.DentalSelect.com/Employers/Forms-and-FAQs/

DENTALSELECT.

Web Account Access
Right at your fingertips!

Employee benefit administration is simple when you use Dental Select's Group Web Portal. Conveniently manage your employee benefits with our easy to use web interface and get training for your staff with on-line tutorials. With access you can update employee profiles, add or terminate benefits, and order ID cards. So, what are you waiting for? Get connected right now!

Connect.

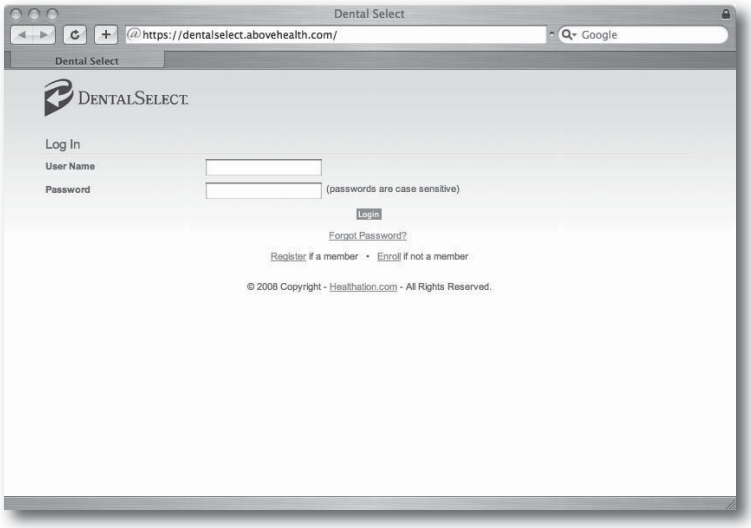
It's Simple:

- Web Portal Administration is easy to use
- Get web account training for your staff with convenient on-line tutorials
- Receive expert help from Dental Select's experienced system administrators

Right.

With Access You Can:

- Enroll employees and dependents*
- Update employee benefits or change them
- Order ID cards or instantly print a temporary
- Terminate employee benefits
- Update employee personal information
- View invoices
- Locate providers
- Add or edit COB information
- Reinstate coverage**



Now!

Get connected today by calling a Dental Select Member Service representative to receive your group username and password at 1-800-999-9789.

*Web Portal Administration requires an initial 834 file for employee enrollment; contact a Member Service representative for additional details.

**Based on eligibility rules

CC.04-09 GWPA

ACE American Insurance Company
Philadelphia, PA 19106

Group Dental Policy

POLICYHOLDER:	GKSD Restaurant Enterprises dba Jack Allen's Kitch
POLICY NUMBER:	14026772
POLICY EFFECTIVE DATE:	01 December, 2018
POLICY ANNIVERSARY DATE:	December 1
STATE OF DELIVERY:	Texas

MONTHLY PREMIUM RATES:

EMP:	$12.65
ESP:	$25.31
ECH:	$37.99
FAM:	$56.46

This Policy describes the terms and conditions of coverage for Group Dental Insurance. The Policy takes effect at 12:01 A.M. on the Policy Effective Date shown above.

By paying the first premium and accepting this Policy, the Policyholder agrees to be bound by the terms of this Policy.

This Policy is governed by the laws of the state in which it is delivered.

Signed for ACE AMERICAN INSURANCE COMPANY at Philadelphia, Pennsylvania

JOHN J. LUPICA, President

REBECCA L. COLLINS, Secretary

Non-Participating Insurance

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POLICY SCHEDULE

Premium Due Date: Premiums are due in advance on the date coinciding with the Policy Anniversary Date or the last day of the month, if earlier.

Participation Requirements:

Contributory: When the Policyholder contributes toward the cost of an Employee's coverage, a minimum of 6 eligible persons is required and 75% of these eligible persons must be enrolled for coverage.

Voluntary: When coverage is paid for entirely by the Employee:

If 2-5 eligible persons, 100% of these eligible persons must be enrolled for coverage.

If 6 or more eligible persons, a minimum of 5 eligible persons must be enrolled for coverage.

CLASSES OF ELIGIBLE PERSONS

Class 1: All full-time employees working at least 30 hours per week.

Eligibility Waiting Period: As selected by the Policyholder on application

If a person is eligible under one Class of Eligible Persons and later becomes eligible under a different Class of Eligible Persons, changes in his or her insurance due to a change in class will be effective on the date the change in class is made.

A person may be insured only once under the policy even if he or she is eligible as both an Eligible Person and a Dependent.

Premium is payable in full at the time of enrollment. There is no refund of premium if a Covered Person withdraws from the plan prior to the period for which premium is paid.

GENERAL POLICY PROVISIONS

Entire Contract: The Policy (including any endorsements or amendments), the signed application of the Policyholder, and any individual applications of Covered Persons, are the entire contract. Any statements made by the Policyholder, or Insureds will be treated as representations and not warranties. No such statement shall void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application.

Changes: To be valid, any change or waiver must be in writing (or authorized electronic or telephonic communications). It must be signed by our President or Secretary and be attached to the Policy. No agent has authority to change or waive any part of the Policy.

Incontestability: This Policy cannot be declared invalid after it has been in force for two years unless the required premium is not paid when due. No statement of health used by any person to get insurance can be used to determine coverage is invalid if the person has been insured under the Policy for at least two years. In order to use a statement of health to deny coverage before the end of two years, it must have been signed by the person. A copy of the statement must be given to the Covered Person or his or her beneficiary.

Clerical Error: If a clerical error is made, it will not affect the insurance of any Covered Person. No error will continue the insurance of a Covered Person beyond the date it should end under the Policy terms.

Termination of the Policy: Either the Policyholder or We may end this Policy at any time by providing the other party with written or authorized electronic or telephonic notice. If We end this Policy, it will be effective on the later of: 1) the date stated in the notice; or 2) 10 days after We deliver the notice. If the Policyholder ends this Policy, it will be effective on the later of: 1) the date We receive the notice; or 2) the date stated in the notice.

Examination Of Records And Audit: We shall be permitted to examine and audit the Policyholder's books and records at any time during the term of the Policy and within 2 years after the final termination of the Policy as they relate to the premiums or subject matter of this insurance.

Certificates Of Insurance: Where it is required by law, or upon the request of the Policyholder, We will make available certificates outlining the insurance coverage and to whom benefits are payable under the Policy.

Participation: A Policyholder is eligible to offer coverage to those persons in the Eligible Classes shown on the Schedule of Benefits on the later of: 1) the Policy Effective Date; or 2) the date a person is eligible, if after the Policy Effective Date. In order to effect coverage for employees, an employer group must meet and continue to maintain the participation requirements set forth on the Schedule of Benefits.

Renewal: Subject to Our consent, a Policyholder's coverage may be renewed on each Policy Anniversary Date. We have the right to refuse to renew a Policyholder's coverage on any Anniversary Date. If we refuse to renew coverage under the Policy, We will provide at least 31 days advanced written or authorized electronic or telephonic notice of Our intent to not renew.

Premium Rates: The initial premium rates to be charged for insurance under this Policy will be based on the schedule of premium rates agreed to by the Policyholder and Us. We may change rates from time to time with at least 31 days advanced written or authorized electronic or telephonic notice. We reserve the right to change rates at any time if any of the following events take place.

1. The terms of the Policy change.
2. A division, subsidiary, affiliated organization or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. Any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

Experience Rating: This Policy is subject to experience rating. This means that We may reduce the premium rates at the end of any policy year due to good experience. We may not increase the premium rates for any policy year due to poor experience in that year.

Premium Due Date: The first Premium is due on the Policyholder's Effective Date. Coverage will not go into effect unless this first premium is paid in full by that date. After that, premiums will be due monthly in advance unless We agree with the Policyholder on some other method of premium payment. Premiums are payable to Us or Our authorized agent by the Premium Due Date shown in the Schedule of Benefits.

If any premium is not paid when due, participation under the Policy will be canceled as of the last day of the period for which premiums were paid, except as provided in the Grace Period provision.

Grace Period: If any premiums (but the first premium payment) 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 Policy Grace Period, insurance will end as of the last day of the period for which premiums were paid. The Policyholder will be liable to Us for any unpaid premium for the time the Policy was in force.

Records To Be Kept By The Policyholder: The Policyholder will keep a record of: 1) each person who is covered under the Policy; and 2) each person's beneficiary, if one is needed. We have the right to see the Policyholder's records. We have the right to audit or inspect these records at any reasonable time to determine who is insured and for any other purpose relating to this insurance.

Not In Lieu Of Workers Compensation: This 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.

Certificate Provisions Made Part Of The Policy: The remainder of this Policy consists of provisions shown in the Certificate under this Policy. The provisions described in the Table of Contents are part of this Policy. Riders and amendments, if any, adding or changing the provisions of the Certificate is also made part of this Policy.

Platinum Network Advantages

The absence of waiting periods and annual maximums creates a competitive co-pay plan with affordable premiums and fixed co-payments for you. Visit any general dentist you choose. Receive the greatest out-of-pocket savings advantage when you receive care from a contracted provider.

Platinum Network Cost Savings

Platinum co-pay general dentists and specialists are available in Texas and Utah only.

Contracted (participating) general dentists. Contracted general dentists accept, as payment in full, a combination of patient co-payments and Plan payments. Refer to the Schedule of Co-Payments for fixed co-payment amounts. All payments made by the Plan are based on the Platinum co-pay fee schedule.

Contracted (participating) specialists. You receive a negotiated discount from the contracted specialist's usual fees for eligible services. There is no Plan payment for services provided by contracted specialists.[1]

Use of a contracted general dentist or 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.

Fee Schedules are subject to change upon notification.

Platinum co-pay contracted providers are available in Texas and Utah only. Providers in all other states will be considered non-network (non-contracted) providers.

Access to Out-of-Network Options

Non-contracted (non-participating) general dentists. All payments made by the Plan for services provided by non-contracted general dentists are based on the Platinum co-pay fee schedule. Charges above the Plan's payment are your responsibility.

Non-contracted (non-participating) specialists. There is no discount or benefit for services provided by a non-contracted specialist.

[1] Except contracted pediatric specialists in the State of Utah, who are contracted to accept the Platinum Network Pediatric Specialist Co-Pay fee schedule as payment in full.

ACE American Insurance Company
Philadelphia, PA 19106

Certificate of Insurance

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

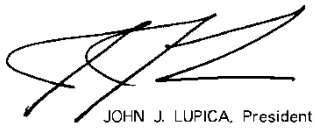
Benefits are payable only for expenses incurred while Your insurance is in force.

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.


JOHN J. LUPICA, President


REBECCA L. COLLINS, Secretary

PLEASE READ YOUR CERTIFICATE CAREFULLY.

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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.

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 26.
3. Each unmarried child at least 26 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 26th birthday; and who continues to be incapacitated beyond his 26th birthday. You must give Us proof of the incapacity and dependency within 30 days of the child's 26th 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: 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 AND CUSTOMARY: 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: means a description of Your benefits including coverage level for services, deductibles, maximums, waiting periods, etc.

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. 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 to continue coverage beyond the first 31-day period. 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 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.

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 Your Dependent ceases to be a Dependent, as defined;
2. last day of the month for which a premium has been paid; or
3. the first of the month following receipt of written notification.

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.

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 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 - the date the first impression is taken.
2. For fixed bridges, 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:
   a. Records - on the date the service is performed;
   b. Initial banding - on the date bands are inserted;
   c. Monthly treatments - on the date the service is performed.
6. For all other services - the date the service is performed.

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

DEDUCTIBLE: The lifetime and calendar 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.

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, Pediodontics, 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 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-TREATMENT REVIEW: If the Course of Treatment is expected to exceed $300.00, We will require prior review. We must be given the Dentist's treatment plan consisting of a description of the planned treatment with estimated charges and diagnostic x-rays. 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. If You do not request a pretreatment review We will pay for the least expensive method of treatment regardless of the method actually 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	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*
• Divorce or legal separation	36 months
• The Insured becomes eligible for Medicare	Dependents allowed 36 months
• An insured Dependent no longer meets the eligibility requirements	36 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 ends.

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;
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 one year from the month and year 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 GROUP SCHEDULE OF BENEFITS

All benefits are based on a contracted fee-for-service schedule.

Contracting General Dentist Services: Participating General Dentists accept the contracted fee schedule as payment in full.

Contracting Provider Services: Participating providers accept the contracted fee schedule as payment in full.

Contracting Specialist Services: Services rendered by a Contracting 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 Contracting Specialists according to the contracted fee schedule.
3. The Insured is responsible for the difference between the discounted fee and Our payment.

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.

Non-Contracting Provider Services: Non-contracting providers may not accept the contracted fee schedule as payment in full. Charges above the contracted fee schedule are the Insured's responsibility. Eligible Expenses will be paid at benefit levels for Non-Contracting Provider if an Insured incurs any Eligible Expenses:

1. for services of a provider who is no longer a Contracting Provider; or
2. when the Insured elects not to use the services or supplies of the Contracting Provider.

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 USA 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:

1. routine examinations and cleanings, topical fluoride (age 14 & under) – 2 per calendar year (in conjunction with all other exams).
2. Panoramic (age 6 & over) or full mouth series x-rays (age 11 & over) – 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:

1. oral surgery - simple extraction of teeth; frenectomy, incision and drainage of intraoral abscess; extraction of impacted tooth; surgical exposure of tooth; 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 & 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 bicuspids and molars – every 36 months (age14 & under);
7. periodontic services: one 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 (once every 5 years; limited services available on same date of service).

Class C. Major Services Include:

1. endodontic treatment: root canal therapy *(age restrictions apply)*; pulpotomy; pulpal therapy; apicoectomy; apexification/recalcification; root amputation; hemisection; intentional reimplantation; retrograde fillings;
2. crown build-up; post and core;
3. recementing inlays, onlays and crowns and bridges;
4. repair of dentures or bridges;
5. 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);
6. addition of teeth to existing partial denture;
7. relining or rebasing of existing removable dentures: 1 per year;
8. occlusal guards for bruxism only: 1 every 2 years;
9. stainless steel crowns: 1 every 2 years;

Class D. Orthodontia Services (non-insured services):

Orthodontia Services are **NOT COVERED** by the Plan. However, the insured receives a negotiated discount from the provider's usual fees when receiving services from a Network Orthodontist.

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

1. for services and supplies not listed in the Coverage Schedule, not recognized as essential for the treatment of the condition according to accepted standards of practice or considered experimental.
2. for services provided by Specialists whether Network or Non-Network.
3. for cosmetic procedures, including but not limited to veneers and bleaching of teeth and procedures performed primarily for cosmetic reasons.
4. for services related to, performed in conjunction with, or resulting from a non-covered procedure.
5. for charges in excess of the contracted Fee-for-Service schedule or the Reasonable and Customary rate, whichever applies.
6. for any treatment program which began prior to the date the Insured is covered under the Policy.
7. for crowns, inlays and onlays on teeth that can be restored by direct placement materials.
8. for the replacement of crowns, bridges, inlays, onlays or prosthetic appliance within 5 years from the date of last placement.
9. for service or supplies payable under any medical expense, auto or no-fault plan.
10. for any condition covered under any Worker's Compensation Act or similar law.
11. 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.
12. for services that are applied toward the satisfaction of a Deductible, if any.
13. for services subject to a waiting period that were incurred during the waiting period.
14. 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. Services by a dentist who is a family member.
15. for hospital facility charges for any dental procedure, including but not limited to: emergency room charges, surgical facility charges, hospital confinement.
16. for drugs or the dispensing of drugs.

17. 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).
18. 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.
19. for orthodontia, unless included within the Summary of Benefits.
20. 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.
21. for composite, resin, or white fillings on posterior primary teeth. Benefit will be reduced to that of an amalgam or silver filling.
22. for the replacement of a filling within 24 months of placement, unless for specific health reasons.
23. for the replacement of retainers.
24. 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.
25. for lab fees for higher metals or porcelain crowns, bridges, inlays or onlays.
26. for general anesthesia or IV sedation.
27. 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.

ACE Group of Companies

Notice of HIPAA Privacy Practices for Protected Health Information

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.

This notice is effective as of September 23, 2013.

The ACE Group of Companies, as affiliated covered and hybrid entities, (the "Company") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information, and to inform you about:

- The Company's uses and disclosures of Protected Health Information ("PHI")
- Your privacy rights with respect to your PHI;
- The Company's duties with respect to your PHI;
- Your right to file a complaint with the Company and to the Secretary of the U.S. Department of Health and Human Services ("HHS"); and
- The person or office to contact for further information regarding the Company's privacy practices.

PHI includes all individually identifiable health information transmitted or maintained by the Company, regardless of form (e.g. oral, written, electronic).

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), regulates PHI use and disclosure by the Company. You may find these rules at *45 Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

I. Notice of PHI Uses and Disclosures

A. Required Uses and Disclosures

Upon your request, the Company is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of Health and Human Services to investigate or determine the Company's compliance with the privacy regulations.

B. Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations

The Company and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Company also may also disclose PHI to a plan sponsor for purposes related to treatment, payment and health care operations and as otherwise permitted under HIPAA to the extent the plan documents restrict the use and disclosure of PHI as required by HIPAA.

Treatment is the provision, coordination or management of health care and related services.

It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Company may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment includes, but is not limited to, actions to make coverage determinations and payment (including establishing employee contributions, claims management, obtaining payment under a contract of reinsurance, utilization review and pre-authorizations). For example, the Company may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Company.

Health care operations include, but are not limited to, underwriting, premium rating and other insurance activities relating to creating or reviewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Company may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions. The Company will not use or disclose PHI that is genetic information for underwriting purposes.

The Company also may contact you to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you.

C. Uses and Disclosures that Require Your Written Authorization

The Company will not use or disclose your PHI for the following purposes without your specific, written authorization:

- Use and disclosure of psychotherapy notes, except for your treatment, Company training programs, or to defend Company against litigation filed by you.
- Use and disclosure for marketing purposes, except for face to face communications with you.
- Use and disclosure that constitute the sale of your PHI. The Company does not sell the PHI of its customers.

Except as otherwise indicated in this notice, uses and disclosures of PHI will be made only with your written authorization subject to your right to revoke such authorization. You may revoke an authorization by submitting a written revocation to the Company at any time. If you revoke your authorization, the Company will no longer use or disclose your PHI under the authorization. However, any use or disclosure made in reliance of your authorization before its revocation will not be affected.

D. Uses and Disclosures Requiring Authorizations or Opportunity to Agree or Disagree Prior to the Use or Release

If you authorize in writing the Company to use or disclose your own PHI, the Company may proceed with such use or disclosure without meeting any other requirements and the use or disclosure shall be consistent with the authorization.

Disclosure of your PHI to family members, other relatives or your close personal friends is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

E. Uses and Disclosures for which Consent, Authorization or Opportunity to Object is Not Required

Use and disclosure of your PHI is allowed without your authorization or request under the following circumstances:

(1) When required by law.

(2) When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls and to conduct post-market surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

(3) When authorized by law to report information about abuse, neglect or domestic violence. In such case, the Company will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law where the parents or other representatives may not be given access to the minor's PHI.

(4) The Company may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(5) The Company may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Company that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

(6) When required for law enforcement purposes (for example, to report certain types of wounds).

(7) For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Company's best judgment.

(8) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(9) The Company may use or disclose PHI for government-approved research, subject to conditions.

(10) When consistent with applicable law and standards of ethical conduct if the Company, in good faith, believes the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(11) For certain government functions such as related to military service or national security.

(12) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

(13) That is "incident to" an otherwise permitted use or disclosure of PHI by the Company.

II. Rights of Individuals

A. Right to Request Restrictions on Use and Disclosure of PHI

You may request the Company to restrict its use and disclosure of your PHI to carry out treatment, payment or health care operations, or to restrict its use and disclosure to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Company may not be required to agree to your request, unless you have paid out of pocket in full for services, depending on the specific facts.

The Company will accommodate reasonable requests to receive communications of PHI by alternative means or alternative locations, such as a location other than your home. The Company will accommodate this request if you state in writing that you would be in danger from receiving communications through the normal means.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests should be made to: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

B. Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Company maintains the PHI.

"*Protected Health Information"* (PHI) includes all individually identifiable health information transmitted or maintained by the Company, regardless of form.

"*Designated Record Set*" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Company is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of Health and Human Services.

C. Right to Amend PHI

You have the right to request the Company to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Company has 60 days after the request to act on the request. A single 30-day extension is allowed if the Company is unable to comply with the deadline. If the request is denied in whole or part, the Company must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

You or your personal representative(s) will be required to complete a form to request amendment of the PHI in your designated record set.

D. Right to Receive an Accounting of PHI Uses and Disclosures

Upon your request, the Company will provide you with an accounting of disclosures by the Company of your PHI during the six (6) years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; or (4) based upon your own written authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Company will charge a reasonable, cost-based fee for each subsequent accounting.

E. Right to Obtain a Paper Copy of This Notice Upon Request (Even if you have consented to receive this notice electronically)

To obtain a paper copy of this notice contact: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

F. Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The Company retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

III. The Company's Duties

The Company is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices and to notify affected individuals of a breach of unsecured PHI. The Company is required to abide by the terms of this notice.

The Company reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Company prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all past and present participants and beneficiaries for whom the Company still maintains PHI. This notice and any revised version of this notice will be posted on the Company's internal website or mailed.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Company or other privacy practices stated in this notice.

A."Minimum Necessary" Standard

When using or disclosing PHI, or when requesting PHI from another covered entity, the Company will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of HHS;
- Uses or disclosures that are required by law; and
- Uses or disclosures that are required for the Company's compliance with legal regulations.

This notice does not apply to information that has been "de-identified." *De-identified information* is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Company may use or disclose "summary health information" to a plan sponsor for obtaining premium bids or modifying, amending or terminating the Company, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Company Sponsor has provided health benefits under the Company; and from which identifying information has been deleted in accordance with HIPAA.

IV. Your Right to File a Complaint with the Company or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Company in care of: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

The Company will not retaliate against you for filing a complaint.

V. Contact Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

VI. ACE Group of Companies Legal Entities

The ACE Group of Companies include the following: ACE American Insurance Company, ACE Property and Casualty Insurance Company, Illinois Union Insurance Company, ACE Fire Underwriters Insurance Company, Combined Insurance Company of America, Combined Life Insurance Company of New York. These companies have designated themselves as *hybrid entities* and only those designated health care components identified by such companies are subject to HIPAA. In addition, these companies are legally separate affiliated companies under common ownership and have designated themselves as a *single covered entity* for purposes of HIPAA compliance.

ACE American Insurance Company
436 Walnut Street
Philadelphia, PA 19106
(Herein called We, Us, Our)

Orthodontia Rider

Effective Date: January 1, 2014
Amendment No.: 010114.MNOrtho

This rider is made a part of the Policy and any Certificate to which it is attached as of the Effective Date shown above. It is subject to all of the terms and provisions the Policy except as state below. In return for the payment of any additional premium, We will provide the coverage described in this rider.

ORTHODONTIA EXPENSE BENEFITS

We will pay for Eligible Expenses incurred by a Covered Person for Orthodontia treatment and services while covered under the Policy. These payments are subject to the Deductible and Maximum Limit shown below. **Benefits will be payable when the charges incurred are: 1) Medically Necessary; 2) ordered by a Doctor or Dentist; and 3) are not otherwise excluded by the Policy.**

Eligible Expenses: We will pay the Usual and Customary Charges incurred for the following dental services.

Code	Description of Service	Scheduled Benefit
00340	Cephalometric Film	50% of UCC*
08010	Initial Consultation	50% of UCC*
08020	Diagnostic Evaluation (includes x-rays)	50% of UCC*
08030	Treatment and Braces (under 19 years)	50% of UCC*
08210	Each Retainer	50% of UCC*
08999	Maxillary Expansion	50% of UCC*

Class of Eligible Persons: Dependents under 19 years of age

Waiting Period: 24 months

"Medically Necessary," for the purposes of this Rider, means the Covered Person has a handicapping malocclusion as a result of birth defects, accident, or abnormal growth patterns. Medical Necessity for orthodontia services are based upon: a) the evaluation of the malocclusion using the Salzmann's Index; and b) evidence of medical necessity provided by the primary dentist, the orthodontist, or the physician. The primary care physician, or the physician or dentist who completes the screening examination may contribute information pertaining to the medical necessity for services.

This rider ends at the same time as the Policy and Certificate. Nothing contained in this Rider will change, waive or extend any provision of the Policy except as stated herein.

Signed for ACE American Insurance Company at Philadelphia, Pennsylvania

JOHN J. LUPICA, President

REBECCA L. COLLINS, Secretary

ACE American Insurance Company P.O. Box 41484
Philadelphia, PA 19101-1484
(Herein called We, Us, Our)

Amendment

Effective Date: January 1, 2015

Amendment #: TXSPEC2015

This Amendment form is made a part of the Policy and any Certificate to which it is attached as of the Effective Date shown above. This form applies only to expenses incurred on or after that date.

The Certificate has been changed as follows:

> **Contracting Specialist Services –** Services rendered by a Contracting Specialist will be reimbursed as follows: after the deductible, We pay Contracting Specialists according to the contracted fee schedule. Use of a Contracting Provider does not guarantee that all changes will be covered under the Policy. All changes are subject to all terms and conditions of the Policy.

This form ends at the same time as the Policy and Certificate. It is subject to all of the terms, limitations and conditions of the Policy and Certificate except as they are changed by it.

Signed for ACE American Insurance Company in Philadelphia, Pennsylvania.

JOHN J. LUPICA, President

REBECCA L. COLLINS, Secretary

ACE Group of Companies

Notice of HIPAA Privacy Practices for Protected Health Information

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.

This notice is effective as of September 23, 2013.

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- Your privacy rights with respect to your PHI;
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- The person or office to contact for further information regarding the Company's privacy practices.

PHI includes all individually identifiable health information transmitted or maintained by the Company, regardless of form (e.g. oral, written, electronic).

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I. Notice of PHI Uses and Disclosures

A. Required Uses and Disclosures

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Use and disclosure of your PHI may be required by the Secretary of Health and Human Services to investigate or determine the Company's compliance with the privacy regulations.

B. Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations

The Company and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Company also may also disclose PHI to a plan sponsor for purposes related to treatment, payment and health care operations and as otherwise permitted under HIPAA to the extent the plan documents restrict the use and disclosure of PHI as required by HIPAA.

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The Company also may contact you to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you.

C. Uses and Disclosures that Require Your Written Authorization

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- Use and disclosure for marketing purposes, except for face to face communications with you.
- Use and disclosure that constitute the sale of your PHI. The Company does not sell the PHI of its customers.

Except as otherwise indicated in this notice, uses and disclosures of PHI will be made only with your written authorization subject to your right to revoke such authorization. You may revoke an authorization by submitting a written revocation to the Company at any time. If you revoke your authorization, the Company will no longer use or disclose your PHI under the authorization. However, any use or disclosure made in reliance of your authorization before its revocation will not be affected.

D. Uses and Disclosures Requiring Authorizations or Opportunity to Agree or Disagree Prior to the Use or Release

If you authorize in writing the Company to use or disclose your own PHI, the Company may proceed with such use or disclosure without meeting any other requirements and the use or disclosure shall be consistent with the authorization.

Disclosure of your PHI to family members, other relatives or your close personal friends is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

E. Uses and Disclosures for which Consent, Authorization or Opportunity to Object is Not Required

Use and disclosure of your PHI is allowed without your authorization or request under the following circumstances:

(1) When required by law.

(2) When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls and to conduct post-market surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

(3) When authorized by law to report information about abuse, neglect or domestic violence. In such case, the Company will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law where the parents or other representatives may not be given access to the minor's PHI.

(4) The Company may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(5) The Company may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Company that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

(6) When required for law enforcement purposes (for example, to report certain types of wounds).

(7) For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Company's best judgment.

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(9) The Company may use or disclose PHI for government-approved research, subject to conditions.

(10) When consistent with applicable law and standards of ethical conduct if the Company, in good faith, believes the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(11) For certain government functions such as related to military service or national security.

(12) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

(13) That is "incident to" an otherwise permitted use or disclosure of PHI by the Company.

II. Rights of Individuals

A. Right to Request Restrictions on Use and Disclosure of PHI

You may request the Company to restrict its use and disclosure of your PHI to carry out treatment, payment or health care operations, or to restrict its use and disclosure to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Company may not be required to agree to your request, unless you have paid out of pocket in full for services, depending on the specific facts.

The Company will accommodate reasonable requests to receive communications of PHI by alternative means or alternative locations, such as a location other than your home. The Company will accommodate this request if you state in writing that you would be in danger from receiving communications through the normal means.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests should be made to: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

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"*Designated Record Set*" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Company is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of Health and Human Services.

C. Right to Amend PHI

You have the right to request the Company to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Company has 60 days after the request to act on the request. A single 30-day extension is allowed if the Company is unable to comply with the deadline. If the request is denied in whole or part, the Company must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

You or your personal representative(s) will be required to complete a form to request amendment of the PHI in your designated record set.

D. Right to Receive an Accounting of PHI Uses and Disclosures

Upon your request, the Company will provide you with an accounting of disclosures by the Company of your PHI during the six (6) years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; or (4) based upon your own written authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Company will charge a reasonable, cost-based fee for each subsequent accounting.

E. Right to Obtain a Paper Copy of This Notice Upon Request (Even if you have consented to receive this notice electronically)

To obtain a paper copy of this notice contact: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

F. Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The Company retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

III. The Company's Duties

The Company is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices and to notify affected individuals of a breach of unsecured PHI. The Company is required to abide by the terms of this notice.

The Company reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Company prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all past and present participants and beneficiaries for whom the Company still maintains PHI. This notice and any revised version of this notice will be posted on the Company's internal website or mailed.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Company or other privacy practices stated in this notice.

A."Minimum Necessary" Standard

When using or disclosing PHI, or when requesting PHI from another covered entity, the Company will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of HHS;
- Uses or disclosures that are required by law; and
- Uses or disclosures that are required for the Company's compliance with legal regulations.

This notice does not apply to information that has been "de-identified." *De-identified information* is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Company may use or disclose "summary health information" to a plan sponsor for obtaining premium bids or modifying, amending or terminating the Company, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Company Sponsor has provided health benefits under the Company; and from which identifying information has been deleted in accordance with HIPAA.

IV. Your Right to File a Complaint with the Company or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Company in care of: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

The Company will not retaliate against you for filing a complaint.

V. Contact Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

VI. ACE Group of Companies Legal Entities

The ACE Group of Companies include the following: ACE American Insurance Company, ACE Property and Casualty Insurance Company, Illinois Union Insurance Company, ACE Fire Underwriters Insurance Company, Combined Insurance Company of America, Combined Life Insurance Company of New York. These companies have designated themselves as *hybrid entities* and only those designated health care components identified by such companies are subject to HIPAA. In addition, these companies are legally separate affiliated companies under common ownership and have designated themselves as a *single covered entity* for purposes of HIPAA compliance.

ACE GROUP OF COMPANIES
U.S. PRIVACY NOTICE

FACTS	**WHAT DOES THE ACE GROUP OF COMPANIES DO WITH YOUR PERSONAL INFORMATION?**
Why?	Insurance companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal and state law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: ▪ Social Security number and payment history ▪ insurance claim history and medical information ▪ account transactions and credit scores When you are no longer our customer, we continue to share information about you as described in this notice.
How?	All insurance companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons insurance companies can share their customers' personal information; the reasons the ACE Group chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	**Does ACE share?**	**Can you limit this sharing?**
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes – to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes – information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	We don't share
For our affiliates to market to you	No	We don't share
For nonaffiliates to market to you	No	We don't share

Questions?	**Call 1-800-352-4462 or go to www.acegroup.com/us-en/contact-us/general-inquiry-form.aspx**

Who we are	
Who is providing this notice?	The ACE Group of Companies. A list of these companies is located at the end of this document.

What we do	
How does ACE Group protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. We restrict access to personal information to our employees, affiliates' employees, or others who need to know that information to service the account or to conduct our normal business operations.
How does ACE Group collect my personal information?	We collect your personal information, for example, when you ▪ apply for insurance or pay insurance premiums ▪ file an insurance claim or provide account information ▪ give us your contact information We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only ▪ sharing for affiliates' everyday business purposes – information about your creditworthiness ▪ affiliates from using your information to market to you ▪ sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. ▪ Our affiliates include those with an ACE name and financial companies, such as Westchester Fire Insurance Company and ESIS, Inc.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. ▪ ACE does not share with nonaffiliates so they can market to you.
Joint Marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. ▪ Our joint marketing partners include categories of companies such as banks.

Other important information

For Insurance Customers in CA, CT, GA, IL, MA, ME, MN, MT, NC, NJ, OH, OR, and VA only: Under state law, you have the right see the personal information about you that we have on file. To see your information, write ACE US Customer Services, P.O. Box 1000, 436 Walnut Street, WA04B, Philadelphia, PA 19106. ACE USA may charge a reasonable fee to cover the costs of providing this information. If you think any of the information is wrong, you may write us. We will let you know what actions we take. If you do not agree with our actions, you may send us a statement. If you want a full description of privacy rights that we will protect in accordance with the law in your home state, please contact us and we will provide it. We may disclose information to certain third parties, such as law enforcement officers, without your permission.

For Nevada residents only: We may contact our existing customers by telephone to offer additional insurance products that we believe may be of interest to you. Under state law, you have the right to opt out of these calls by adding your name to our internal do-not-call list. To opt out of these calls, or for more information about your opt out rights, please contact our customer service department. You can reach us by calling **1-800-352-4462**, emailing us at info@acegroup.com, or writing to P.O. Box 1000, 436 Walnut Street, WA04B, Philadelphia, PA 19106. You are being provided this notice under Nevada state law. In addition to contacting ACE, Nevada residents can contact the Nevada Attorney General for more information about your opt out rights by calling 775-684-1100, emailing bcpinfo@ag.state.nv.us, or by writing to: Office of the Attorney General, Nevada Department of Justice, Bureau of Consumer Protection: 100 North Carson Street, Carson City, NV 89701.

For Vermont residents only: Under state law, we will not share information about your creditworthiness within our corporate family except with your authorization or consent, but we may share information about our transactions or experiences with you within our corporate family without your consent.

ACE Group of Companies legal entities

ACE Group of Companies use the names: ACE American Insurance Company, ACE Fire Underwriters Insurance Company, ACE Insurance Company of the Midwest, ACE Property and Casualty Insurance Company, Atlantic Employers Insurance Company, Bankers Standard Fire and Marine Company, Bankers Standard Insurance Company, Century Indemnity Company, Illinois Union Insurance Company, Indemnity Insurance Company of North America, Insurance Company of North America, Pacific Employers Insurance Company, Westchester Fire Insurance Company, Westchester Surplus Lines Insurance Company, ESIS, Inc., Combined Insurance Company of America, Combined Life Insurance Company of New York, Penn Millers Insurance Company, Agri General Insurance Company

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION (For insurers declared insolvent or impaired on or after September 1, 2005)

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect Texas policyholders if their life or health insurance company fails. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not cover your policy in full or in part due to statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at that time **(irrespective of the policyholder's residency at policy issue)**
- Residents of other states, ONLY if the following conditions are met:
    1. The policyholder has a policy with a company domiciled in Texas;
    2. The policyholder's state of residence has a similar guaranty association; and
    3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on any one life; or
- Death benefits up to a total of $300,000 under one or more policies on any one life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
6504 Bridge Point Parkway, Suite 450
Austin, Texas 78730
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us