ASSURANT
Employee
Benefits

Group Benefits

Earnhardt Management Company

Voluntary Dental

CERTIFICATE OF
GROUP INSURANCE

Union Security Insurance Company certifies that the insurance stated in this Certificate became effective on the Effective Date shown in your Schedule. This Certificate is subject to the provisions of the below numbered *policy* issued by Union Security Insurance Company to the *policyholder*.

Policyholder: Earnhardt Management Company

Group Policy Number: 5299324

Participation Number: 0

Effective Date: For any dental expenses incurred on or after March 1, 2015.

This Certificate replaces any and all Certificates and Certificate Endorsements, if any, issued to you under the *policy*.

President and
Chief Executive Officer

SCHEDULE

Eligible Persons

To be eligible for insurance, a person must be a member of an Eligible Class. The person must also complete a period of continuous service (Service Requirement) with the *policyholder* (or any *associated company*).

Eligible Class:

For employee insurance – Each *full-time* Shareholder or employee of the *policyholder* or an *associated company,*

- who is at *active work*, and
- who is working in the United States of America,

as identified on the *policyholder's* or our records, except any person enrolled in the Prepaid Dental plan or temporary or seasonal worker.

For dependent insurance - Each person eligible and insured for employee insurance.

Associated Companies:
Earnhardt Chrysler Dodge Jeep Ram
Earnhardt Ford
Earnhardt Honda
Earnhardt Toyota Scion
Earnhardt Buick GMC
Rodeo Ford
Earnhardt Kia
Earnhardt Hyundai, Avondale Hyundai
Earnhardt Hyundai, North Scottsdale
Earnhardt Scottsdale Lexus
Earnhardt Cadillac
Chandler Cadillac
Rodeo Kia
Peoria Kia
Earnhardt Maserati
Earnhardt Mazda
San Tan Volkswagen
Earnhardt Liberty Kia
Earnhardt Nissan

Service Requirement: 60 days

Entry Date

Insurance will take effect on the later of (i) the date shown below, and (ii) the first of the month occurring on or after the day all the eligibility requirements are met.

Effective Date of Insurance

The dental insurance provisions of the certificate are effective for any dental expenses incurred on or after March 1, 2015 (subject to Entry Date).

Dental Insurance

Deductible Amount	**PPO Plan** (In-Network Plan)	**Non-PPO Plan** (Out-of-Network Plan)
Individual Deductible Amount Per *Policy Year*:	$50	$50

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

Covered dental services incurred toward the deductible amount apply to both the PPO and Non-PPO Plans.

Coinsurance Percentages	**PPO Plan** (In-Network Plan)	**Non-PPO Plan** (Out-of-Network Plan)
Type I Services:	100%	100%
Type II Services:	90%	80%
Type III Services:	60%	50%

Benefit Maximums:	**PPO Plan** (In-Network Plan)	**Non-PPO Plan** (Out-of-Network Plan)
Policy Year Maximum:	$1,500	$1,500

Amounts applied to the benefit maximums will apply to both the PPO Plan and Non-PPO Plan maximums.

Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the Listing of Covered Dental Services. However, benefits will be payable based on the most current dental terminology.

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

Vision Plan

You and your *covered dependents* are eligible for discounted vision services. **The discounted vision services are provided through a third party vendor and are not covered under an insured plan.** The discounted vision services offered include discounts on eye exams, prescription glasses, and services related to prescription contact lenses.

Plan Changes

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

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

SCHEDULE (continued)

A "change in family status" means your marriage or divorce, the birth or adoption of your child, the death of your spouse or child, the termination of employment of your spouse, or any other event specified in the *policyholder's* IRC Section 125 plan, if any.

The "Waiting Periods for Insured Persons Generally" provision, if any, will apply to changes made by timely applicants during an annual enrollment period and due to a change in family status.

The "Additional or Longer Waiting Periods for Late Entrants" provision, if any, will apply to any person who applies for insurance more than 31 days after the date the person first becomes eligible or after insurance ended because the premium was not paid.

TABLE OF CONTENTS

GENERAL DEFINITIONS

These terms have the meanings shown here when *italicized*. The pronouns "we", "us", "our", "you", and "your" are not *italicized*.

Active work means working *full-time* for the *policyholder* or an *associated company* at your usual place of business.

Associated company means any company shown in the *policy* which is owned by or affiliated with the *policyholder*.

Contributory means you pay part or all of the premium.

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

Covered person means an eligible employee or member of the *policyholder*, or an *associated company* who has become insured for a coverage.

Doctor means a person, other than you, acting within the scope of his or her license to practice medicine and perform surgery.

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

Full-time means working at least 32 hours per week, unless indicated otherwise in the *policy*.

Home office means our office in Kansas City, Missouri.

Injury means accidental bodily injury. It does not mean intentionally self-inflicted injury while sane or insane.

No-fault motor vehicle coverage means a motor vehicle plan that pays disability or medical benefits without considering who was at fault in any accident that occurs.

Policy means the group policy issued by us to the *policyholder* that describes the benefits for which you may be eligible.

Policyholder means the entity to whom the *policy* is issued.

Proof of good health means evidence acceptable to us of the good health of a person.

We, us, and our mean Union Security Insurance Company.

You and your mean an eligible employee or member of the *policyholder* or an *associated company* who has become insured for a coverage.

DEFINITIONS FOR DENTAL INSURANCE

Accidental non-chewing injury means an *injury* (other than a chewing injury) sustained while insured under the *policy*, which is caused solely and exclusively by an accident which could not be predicted in advance, and which could not be avoided. A chewing injury is any *injury* which occurs during the act of biting or chewing, regardless of whether the *injury* is caused by biting or chewing food, biting on a foreign object not expected to be a normal constituent of food, parafunctional or abnormal habits such as (but not limited to) chewing on eyeglass frames or pencils, biting down on a suddenly dislodged or loose dental appliance, or biting or chewing on any other object for any other reason.

Allowable charge means:

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

- For a covered dental service rendered by a *non-preferred provider*, the *allowable charge* is the *reasonable charge*. The r*easonable charge* is the amount, as determined by us, accepted by providers in the area for like dental services. Our determination of what is an *allowable charge* or *reasonable charge* is final for the purposes of determining benefits payable under the *policy*.

Benefit year means a period of 12 consecutive months, which begins on the date you become insured under the *policy*. Subsequent *benefit years* begin on each succeeding anniversary of the date you became insured under the *policy*.

Continuous coverage/continuously covered means, with respect to a *transfer insured's* coverage under the *prior plan*, the most recent period of continuous coverage under the *prior plan* ending on the day before the effective date of this *policy*.

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

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

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

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

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

- any supporting pre-operative x-rays; and

- any other appropriate diagnostic materials required by us.

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

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

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

Functioning natural tooth means a *natural tooth* which is performing its normal role in the chewing process in the person's upper or lower arch and which is opposed in the person's other arch by another *natural tooth* or prosthetic replacement.

Immediate family means a person who is related to you or your spouse in any of the following ways: parent, spouse, child, brother, sister, or grandparent.

Medicare means a portion of Title XVIII of the United States Social Security Act of 1965, as amended.

Natural tooth means any tooth or part of a tooth that is organic and formed by the natural development of the body. Organic portions of the tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp.

Non-preferred provider means a *dentist, dental hygienist,* dental office, medical center, or any dental care provider who is not a participant in our *preferred provider plan* at the time covered dental services are provided.

Orthodontic treatment means the corrective movement of teeth through the bone by means of an active appliance to correct a handicapping malocclusion (a malocclusion severely interfering with a person's ability to chew food) of the mouth. We will make the determination of the severity of the malocclusion.

Other group dental expense coverage means:

- any other group policy providing benefits for dental expenses; or
- any plan providing dental expense benefits (whether through a dental services organization or other party providing prepaid health or related services) which is arranged through any employer or through direct contact with persons eligible for that plan.

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

Preferred provider means a *dentist, dental hygienist*, dental office, or medical center or any dental care provider who is a participant in our *preferred provider plan*.

Preferred provider plan means the dental care delivery system established by the plan manager in which *preferred providers* participate and under which we provide certain dental benefits.

Prior Plan means the policy(ies) or plan(s) providing dental care coverage to persons of the group, which is (are) replaced by insurance under our *policy* on the *policy* effective date.

Sound tooth means a *natural tooth* that is fully restored to function, does not have any decay, is not more susceptible to *injury* than a virgin tooth, and is without periodontal disease.

Transfer insured means a person who both is insured under our *policy* on the *policy* effective date (without regard to the Exception to Effective Date provision) and was covered under the *prior plan* on the day just before that; but only so long as the person remains continuously insured under our *policy*. The Exception to Effective Date provision does not apply to such *transferred insureds*. The Continuance of Insurance provision applies to such *transferred insureds* that are not at *active work* on the *policy* effective date. However, the maximum continuation period will begin on the *policy* effective date.

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

ELIGIBILITY AND TERMINATION PROVISIONS FOR YOU

Exception to Effective Date

If you are not at *active work* on the day you would otherwise become insured, your insurance will not take effect until you return to *active work*. If the day your insurance would normally take effect is not a regular work day for you, your insurance will take effect on that day if you are able to do your regular job.

When Your Insurance Ends

Your insurance will end on the earliest of:

- the day the *policy* ends;
- the day the *policy* is changed to end the insurance for your *eligible class*;
- the last day of the month in which you are no longer in an *eligible class*;
- the last day of the month in which you stop *active work*;
- the day a required contribution was not paid; or
- the day you become covered under an optional dental plan which is sponsored by your employer, or the *policyholder*, or an *associated company* and provided through a Dental Maintenance Organization.

ELIGIBILITY AND TERMINATION PROVISIONS FOR DEPENDENTS

Eligible Dependents

Your *eligible dependents* are:

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

"Children" include any adopted children. A child will be considered adopted on the date of placement in your home. Stepchildren and foster children are also included if they depend on you for support and maintenance. "Children" also include any children for whom you are the legal guardian, who reside with you on a permanent basis and depend on you for support and maintenance.

An *eligible dependent* will not include any person who is a member of an *eligible class*. An *eligible dependent* may not be covered by more than 1 *covered person*.

Dependent Effective Date

You must apply for dependent insurance on a form acceptable to us. You must also agree to pay your share of the premium.

- If you apply before the dependent becomes eligible, dependent insurance will take effect on the Entry Date shown in the Schedule in the *policy*.
- If you apply on the date the dependent becomes eligible, or within 31 days after that, dependent insurance will take effect on the Entry Date occurring on or after the date of your application.
- If you apply more than 31 days after the date the dependent becomes eligible or after dependent insurance ended because the premium was not paid, then application must be made during an annual enrollment period. Dependent insurance will take effect on the policy anniversary occurring on or after the date of application.

Exception to Dependent Effective Date

Dependent insurance will not take effect until your insurance for the same coverage under the *policy* takes effect.

If an *eligible dependent* is in a hospital or similar facility on the day insurance would otherwise take effect, it will not take effect until the day after the *eligible dependent* leaves the hospital or similar facility. This exception does not apply to a child born while dependent insurance is in effect.

When Dependent Insurance Ends

A dependent's insurance will end on the earliest of:

- the day the *policy* ends;
- the day the *policy* is changed to end dependent insurance;
- the last day of the month in which that dependent is no longer eligible;
- the day your insurance for the same coverage under the *policy* ends;

- the day a required contribution for dependent insurance was not paid; or
- the day the dependent becomes covered under an optional dental plan which is sponsored by your employer, or the *policyholder*, or an *associated company* and provided through a Dental Maintenance Organization.

SPECIAL DEPENDENT INSURANCE CONTINUANCE PROVISIONS

As specified below, dependent *dental insurance* may continue, subject to the provisions that describe when insurance ends, and all other terms and conditions of the *policy*. Premiums are required for any coverage continued.

Physically Handicapped or Mentally Retarded Dependent Children

Dependent *dental insurance* for an *eligible dependent* child will continue beyond the date a child attains an age limit, if, on that date, he or she:

- is unable to earn a living because of physical handicap or mental retardation; and
- is chiefly dependent upon you for support and maintenance.

We must receive proof of the above within 120 days after the child attains the age limit and each year after that, beginning 2 years after the child attains the age limit. There will be no increase in premium for this continued coverage.

Dependent *dental insurance* will end when the child is able to earn a living or is no longer dependent on you for support and maintenance.

SPECIAL FEDERAL CONTINUANCE PROVISIONS

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your *covered dependents* may have the right to continue *dental insurance* coverage beyond the date insurance would otherwise terminate. You should contact the *policyholder* concerning your right to continue coverage.

DENTAL INSURANCE

Insurance Provided

We will pay benefits for covered dental expenses identified in the *policy* when incurred by you or a *covered dependent*, while covered under the *policy*. We will pay the coinsurance percentage shown in the Schedule after you or a *covered dependent* have satisfied any deductible required for the *policy year*, subject to all the terms and conditions of the *policy*.

Covered dental expenses will only include *treatment* provided to you or a *covered dependent* for which, as outlined in the Listing of Covered Dental Services provision, the date started and the date completed occur while the person is insured under the *policy*. No payment will be made for a program of dental *treatment* already in progress on the effective date of a person's insurance, except as stated in the Limited Benefits for Transferred Insureds' Services provision. No payment will be made for dental *treatment* completed after your or a *covered dependent's* insurance under the *policy* ends, except as stated in the Limited Extension of Benefits After Insurance Ends provision.

Preferred Provider Plan

This *policy* includes a *preferred provider plan*. We will provide the benefits of the *preferred provider plan*, as shown in the Schedule, for covered expenses incurred by you or a *covered dependent* if the *treatment* is provided by a *preferred provider*. You will receive maximum benefits available under the *policy* when you obtain covered dental services from a *preferred provider*. You or a *covered dependent* must be identified as being insured under the *preferred provider plan* each time *treatment* is received, to obtain the benefits of the *preferred provider plan*. We will provide the benefits of the non-preferred provider plan, as shown in the Schedule, for covered dental expenses incurred by you or a *covered dependent* if the *treatment* is provided by a *non-preferred provider*.

We reserve the right to terminate a *preferred provider* or the *preferred provider plan*. If we do terminate a *preferred provider* or the *preferred provider plan*, the benefit for a covered dental service will be the benefit payable for a covered dental service from a *non-preferred provider*.

Deductible

The deductible is the amount shown in the Schedule and will be applied to each type of dental services as indicated in the Schedule. The deductible is the amount of covered dental expenses that you and each *covered dependent* must incur in a *policy year* before we will pay benefits. When covered dental expenses equal to the deductible amount have been incurred and submitted to us, the deductible will be satisfied. We will not pay benefits for covered dental expenses applied to the deductible.

If the deductible amount is increased during a *policy year*, further covered dental expenses must be incurred after the date of increase to satisfy the additional deductible for that *policy year*.

The deductible will apply to you and each *covered dependent* separately each *policy year*.

Policy Year Maximum

The maximum benefit payable to you and each *covered dependent* during a *policy year* is shown in the Schedule. This maximum will apply even if coverage for you or a *covered dependent* ends and starts again within the same *policy year* or if you or a *covered dependent* have been covered both as an employee and a dependent.

Date Started and Date Completed

We consider a dental *treatment* to be started as follows:

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

We consider a dental *treatment* to be completed as follows:

- for a full or partial denture, the date a final completed appliance is first inserted in the mouth;
- for a fixed partial denture, crown, inlay and onlay, the date an appliance is cemented in place; and
- for root canal therapy, the date a canal is permanently filled.

Pre-estimate

Whenever the expected cost of a *treatment* exceeds $300, we recommend that a *dental treatment plan* be submitted to us for review before *treatment* begins. The *dental treatment plan* should be accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials as requested by us. We will notify you and your *dentist* of the benefits payable based upon the *dental treatment plan*. In estimating the amount of benefits payable, consideration will be given to the least costly alternative procedures and materials that may accomplish a result that meets broadly accepted standards of professional dental care as determined by us.

If a *dental treatment plan* is not completed within six months of the pre-estimate, we may consider it invalid. We may request the submission of a new d*ental treatment plan*.

If you and your *dentist* decide on a more costly method of *treatment* than that pre-estimated by us, benefits payable for covered dental services for the more costly *treatment* will be limited to the benefits that would have been payable for covered dental services for the least costly alternative *treatmen*t. We will not pay the excess amount. Since this may result in significant out-of-pocket expense, we strongly encourage you to receive a pre-estimate for any *dental treatment plan* that is expected to exceed $300 in cost.

Alternative Benefits

In determining the benefits payable on a claim, we will consider other alternative procedures and materials that can be used to treat a dental problem or disease. The covered dental expense for a covered dental service provided will be limited to the *allowable charge* for the least costly covered dental service that accomplishes a result which meets broadly accepted standards of professional dental care as determined by us. You and your *dentist* may decide on a more costly procedure or material than we have determined to be satisfactory for the *treatment* of the dental problem or disease. In this event, we will not pay the excess amount. The benefit payable will be limited to the benefit that would have been payable had the least costly covered dental service been provided instead.

Covered Dental Expenses

Covered dental expenses for a *preferred provider* will include only the amount that the *preferred provider* has agreed to accept for expenses incurred by you or a *covered dependent*. Covered dental expenses for a *non-preferred provider* will include only the lesser of the *dentist's* actual charge or the *allowable charge* for expenses incurred by you or a *covered dependent*. The *treatment* must be:

- performed by or under the direction of a *dentist*, or performed by a *dental hygienist* or *denturist*;
- *dentally necessary*; and
- started and completed while you or your *covered dependent* are insured, except as otherwise provided in the Limited Benefits for Transfer Insureds' Services Started Under Prior Plan and Limited Extension of Benefits After Insurance Ends provisions.

Expenses submitted to us must identify the *treatment* performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request X-rays, narratives and other diagnostic information, as we see fit, to determine benefits.

We will only pay benefits for covered dental expenses incurred for *treatment* that, in our opinion, has a reasonably favorable prognosis for the patient.

We consider a temporary *treatment* to be an integral part of the final *treatment*. The sum of the fees for temporary and final *treatment* will be used to determine whether the charges are an *allowable charge*.

The Listing of Covered Dental Services is a complete list of covered dental services. We will not pay benefits for expenses incurred for any service not listed below, unless we agree to accept an unlisted service as a covered dental service. We will not accept any unlisted service which is not similar to, or which does not accomplish a result similar to, a listed service. In any event, the choice of whether or not to accept an unlisted service is solely ours. If we do accept an unlisted service as a covered dental service, benefits will be payable on a basis consistent with benefits for similar covered dental services which would provide the least costly adequate *treatment* of your or your *covered dependent's* dental condition according to broadly accepted standards of professional dental care as determined by us.

Listing of Covered Dental Services

Maximum frequencies, maximum dollar amounts and other limits are shown here and under Special Limitations and General Exclusions for certain services. Services performed outside these limits are not covered dental services. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the Listing of Covered Dental Services. However, benefits will be payable based on the most current dental terminology.

Type I Dental Services

- Clinical Oral Evaluations
  - No more than 1 time in any 6 months in a row. Benefits are based on the *allowable charge* for periodic oral evaluation.
- Dental Prophylaxis
  - No more than 1 time in any 6 months in a row.

- Topical Fluoride Treatment
    - No more than 1 time in any 12 months in a row. Only for children under age 14 years.
- Sealants
    - No more than 1 time per tooth per person. Only for children under age 16 years. Only for permanent molar teeth.
- Space Maintenance (Passive Appliances)
    - Only for children under age 16 years. Service is deemed to include all adjustments made, or recementing done, within 6 months of installation.
- Treatment To Control Harmful Habits
    - Not covered if orthodontic related. Once per person. Only for children under age 16 years.
- Radiographs—Diagnostic Imaging
    - Bitewings—no more than 1 time in any 12 months in a row.

Type II Dental Services

- Radiographs—Diagnostic Imaging
    - Complete Series (Including Bitewings) or Panoramic Film—No more than 1 time in any 60 months in a row. A complete series is deemed to include bitewing x-rays and 10 or more periapical x-rays, or a panoramic film.
        - One of either service no more than 1 time in any 60 months in a row. Benefits for a panoramic film may also be payable in connection with the removal of impacted teeth.
    - Periapical—no more than 4 x-rays in any 12 months in a row.
    - Occlusal Film—no more than 2 films in any 12 months in a row.
    - Extraoral—no more than 2 films in any 12 months in a row.
    - Sialography
- Minor Restorations (Fillings)
    - Amalgam and Composite Restorations
        - Replacement of existing minor restoration (filling) is deemed to be a covered dental service only if at least 24 months have passed since existing minor restoration (filling) was placed, unless required by new decay in an additional tooth surface.
        - The service is deemed to include local anesthesia.

- Multiple restorations on one surface are deemed to be a single restoration.
- Mesial-lingual, distal-lingual, mesial-facial, and distal-facial resin restorations on anterior teeth are deemed to be single surface restorations.

- Other Restorative Services
  - Pin Retention—no more than 1 time per restoration. Deemed to be a covered dental service only in conjunction with amalgam or resin restoration.
- Oral Surgery
  - Minor Oral Surgery—Each service is deemed to include local anesthesia and routine postoperative care.
    - Simple Extractions (Does not include Surgical Extractions)
    - Surgical Incision and Drainage of Abscess
    - Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
- Endodontics—For applicable procedures, the service is deemed to include all pre-operative, operative, and post-operative x-rays, local anesthesia, and routine follow-up care.
  - Pulpotomy—Only for Deciduous Teeth
  - Endodontic Therapy
  - Endodontic Retreatment—Service is deemed a covered dental service if at least 24 months have passed since the initial treatment.
  - Apexification-Recalcification Procedures
  - Apicoectomy Surgery
  - Periradicular Services
    - Retrograde Filling
    - Root Amputation
- Other Endodontic Procedures
  - Hemisection (Including any root removal), Not Including Endodontic Therapy—covered dental services do not include fixed partial dentures replacing the extracted part of a hemisected tooth.
- Minor Periodontics
  - Adjunctive Periodontal Service

- Provisional Splinting—covered dental services do not include inlays, onlays, crowns, or other cast or prepared restorations made for the purpose of splinting.
- Scaling and Root Planing—no more than 1 time per area of the mouth in any 24 months in a row. The benefit for three or more quadrants of scaling and root planing, performed during the same appointment, will be limited to benefits equivalent to one quadrant of scaling and root planing. Benefits for prophylaxis and scaling and root planing, performed during the same appointment, will be based on the *allowable charge* for a prophylaxis. Benefits for scaling and root planing and periodontal maintenance, performed during the same appointment, will be based on the *allowable charge* for periodontal maintenance.
- Occlusal Adjustment—No more than 1 full mouth treatment in any 12 months in a row. Only when performed with periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service).

- Other Periodontal Services
  - Periodontal Maintenance—no more than 1 time in any 6 months in a row. Service is deemed to include scaling and root planing, a recall evaluation, charting, polishing of teeth, and oral hygiene instruction.
- Major Periodontics—For applicable procedures, services are deemed to include local anesthesia, temporary restorations and appliances, and one-year follow-up care.
  - Surgical Services—If more than one periodontal surgical service is performed per area of the mouth, only the most inclusive surgical service performed will be considered a covered dental expense. The following surgeries are covered only if more than 36 months have passed since gingivectomy, flap surgery, or osseous surgery was performed in that same area of the mouth.
    - Gingivectomy or Gingivoplasty
    - Gingival Flap Procedure
    - Osseous Surgery
  - Clinical Crown Lengthening
  - Guided Tissue Regeneration
  - Soft Tissue Graft
  - Subepithelial Connective Tissue Graft
  - Distal or Proximal Wedge
  - Occlusal Guard—No more than 1 in any 24 months in a row.
- Other Type II Services
  - Bacteriologic Studies for Determination of Pathologic Agents

- Palliative (Emergency) Treatment of Dental Pain—Minor Procedure—Deemed to be a separate covered dental service only if no other service is rendered during the visit, except x-rays.
- Therapeutic Drug Injection
- Accession and examination of tissue

Type III Dental Services

(The following services may be subject to waiting periods.)

- Complex Oral Surgery
  - Surgical Extractions
- Other Complex Oral Surgery Procedures
  - Oroantral Fistula Closure
  - Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth and/or Alveolus
  - Tooth Transplantation
  - Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption
  - Biopsy of Oral Tissue
  - Transseptal Fiberotomy
  - Alveoplasty
  - Vestibuloplasty
  - Removal of lateral exostosis—maxilla or mandible
  - Removal of Foreign Body, Skin, or Subcutaneous Areolar Tissue
  - Removal of Reaction-Producing Foreign Bodies Musculoskeletal System
  - Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body
  - Frenulectomy (Frenectomy or Frenotomy) Separate Procedure
  - Excision of Hyperplastic Tissue - Per Arch
  - Excision of Pericoronal Gingiva
  - Sialolithotomy
  - Excision of Salivary Gland
  - Sialodochoplasty

- Closure of Salivary Fistula

If more than one complex surgical procedure is performed per area of the mouth, only the most inclusive surgical procedure performed will be considered a covered dental expense.

- Adjunctive General Services—Each service is deemed a separate covered dental service only when medically required for a complex oral surgery which is itself a covered dental service. Our decision is final for the purposes of determining covered dental services under the policy.
  - Anesthesia
  - Intravenous Sedation
- Major Restorations—Initial (New) or Replacement. For applicable procedures, the service is deemed to include local anesthesia, temporary restorations and appliances, and one-year follow-up care.
  - Inlay/Onlay Restorations
    - Benefits are based on the *allowable charge* of a metallic inlay or onlay.
  - Crowns
    - Benefits are based on the *allowable charge* for predominantly base metal.
    - For children under age 16 years, covered dental services for crowns on deciduous or primary teeth are limited to prefabricated stainless steel or prefabricated resin crowns.
  - Labial Veneers (Only for Anterior Teeth)
  - Other Restorative Services—Only under unusual circumstances when required, as determined by us, for retention and preservation of the tooth. Service is deemed to include pins.
    - Core Build-up, Including Any Pins
    - Cast Post And Core
    - Prefabricated Post And Core
- Complete Dentures And Partial Dentures
  - Service is deemed to include all replacement teeth and all clasps and rests.
- Fixed Partial Denture Pontics
  - Fixed Partial Denture Retainers, Inlays/Onlays, And Crowns—Benefits based on the *allowable charge* for predominantly base metal.

  - Two or more contiguous spans of fixed partial denture work, regardless of the number of pontics and abutments involved, are deemed to be a single fixed partial denture with benefits payable based on a single date completed. Benefits for such a fixed partial denture will not be applied to more than one *policy year*.

- Tissue Conditioning
  - No more than 1 time in any 36 months in a row.
  - Only if at least 12 months have passed since the insertion of a full or partial denture.
- Major Restorations—Maintenance—For applicable procedures, the service is deemed to include local anesthesia, temporary restorations and appliances, and one-year follow-up care. Covered only if more than 6 months have passed since the initial insertion.
  - Recement Inlays
  - Recement Crown
  - Recement Fixed Partial Denture
  - Crown Repair
- Repairs To Complete Dentures, Partial Dentures Or Fixed Partial Dentures
  - Only if more than 6 months have passed since the initial insertion.
- Adjustment To Dentures
  - No more than 1 time in any 12 months in a row. Only if more than 6 months have passed since the initial insertion.
- Denture Rebase Procedures
  - No more than 1 time in any 36 months in a row. Only if more than 12 months have passed since the initial insertion.
- Denture Reline Procedures
  - No more than 1 time in any 36 months in a row. Only if more than 12 months have passed since the initial insertion.
- Other Type III Services
  - Diagnostic Casts—No more than 1 time in any 36 months in a row. Only if required for extensive bilateral prosthetic dentistry other than dentures. Not a covered dental service if for orthodontic evaluation.

Special Limitations

Additional or Longer Waiting Periods for Late Entrants

Certain insured persons are deemed to be *late entrants*, as defined under the Definitions for Dental Insurance. A *late entrant* must serve a waiting period of 12 months for any Type II Dental Service and a

waiting period of 24 months for any Type III Dental Service, except for covered dental services for *dentally necessary treatment* of an *accidental non-chewing injury* sustained more than 90 days after the beginning of the waiting period.

Major Restorations

Covered Dental Expenses and covered dental services do not include, and we will not pay benefits for, the following:

- Inlays, onlays, crowns, cast restorations, veneers or other laboratory prepared restorations:
    - on teeth which may be restored with a direct placement filling material;
    - in the absence of extensive decay or fracture;
    - for loss of tooth structure due to attrition or abrasion; or
    - for children under age 16 years, except for prefabricated stainless steel or prefabricated resin crowns on deciduous or primary teeth.
- The initial placement of a complete or partial denture unless:
    - it includes the replacement of a *functioning natural tooth* extracted while you or your *covered dependent* are insured under the *policy*; and
    - that tooth cannot be added to an existing partial denture. We will not pay benefits for the initial placement of a complete or partial denture which replaces only those *natural teeth* missing on the date your or your *covered dependents'* insurance begins.
- The initial placement of a fixed partial denture unless:
    - it includes the replacement of a *functioning natural tooth* extracted while insured under the *policy*; and
    - that tooth was not an abutment to an existing fixed partial denture that is less than 7 years old (5 years old if a cast metal, resin bonded fixed retainer). Benefits for such initial placement are limited to benefits for the replacement of those *functioning natural teeth* which were extracted while you or your *covered dependent* are insured under the *policy* and were not abutments to an existing fixed partial denture less than 7 years old (5 years old if a cast metal, resin bonded fixed retainer). We will not pay benefits to replace *natural teeth* missing on the date that your or your *covered dependent's* insurance begins.
- The replacement of inlays, onlays, crowns, core build-ups, cast restorations, or other laboratory prepared restorations unless:
    - at least 7 years have passed since the last placement (5 years for labial veneers, 3 years for prefabricated stainless steel or prefabricated resin crowns); and
    - they are not serviceable and cannot be restored to function.
- The replacement of a complete or partial denture, or the addition of teeth to a partial denture, unless:

- replacement occurs at least 5 years after the initial date of insertion of the existing denture, provided the existing denture is not serviceable and cannot be restored to function; or

- the addition of a tooth to a partial denture is required due to the *dentally necessary* extraction of a f*unctioning natural tooth* while you or your *covered dependent* are insured under the *policy*; or

- the replacement is made *dentally necessary* by an *accidental non-chewing injury* to a *sound natural tooth*, provided the replacement is completed within 12 months of the injury.

- The replacement of a fixed partial denture unless:

  - replacement occurs at least 7 years (5 years for a cast metal, resin bonded fixed retainer) after the initial date of insertion of the existing fixed partial denture, provided the existing fixed partial denture is not serviceable and cannot be restored to function; or

  - replacement is required due to the *dentally necessary* extraction of a *functioning natural tooth* while *you or your covered dependent* are insured under the *policy*, *provided* that the extracted tooth was not serving as an abutment to the existing fixed partial denture; or

  - replacement is made, provided the replacement is made *dentally necessary* by an *accidental non-chewing injury* to a *sound natural tooth*, and is completed within 12 months of the injury.

- The replacement of an existing partial denture with fixed partial denture work unless upgrading to fixed partial denture work is essential, as determined by us, to the correction of *your or your covered dependent's* dental condition.

- The replacement of teeth beyond the normal complement.

- Appliances, inlays, onlays, crowns, or other cast or laboratory prepared restorations used primarily for the purpose of splinting.

- Facings on crowns or fixed partial dentures on molar teeth (which are always considered cosmetic under the *policy*).

- Implants, insertion of implants or related appliances, or surgical removal of implants.

Coverage Under the Group's Medical Plan

If benefits for any covered dental expenses are provided under your employer's medical plan (if any), benefits otherwise payable for those expenses under the *policy* will be reduced by the amount of benefits payable for those expenses under your employer's medical plan.

General Exclusions

Covered dental expenses and covered dental services do not include, and we will not pay benefits for, the following:

- *treatment* which:

- is not included in the list of covered dental services; or
- has a date started before your or a *covered dependent's* insurance begins; or
- has a date started before any applicable Waiting Period has been served; or
- has a date completed after your or a *covered dependent's* insurance ends, except as may be specifically provided under Limited Extension of Benefits After Insurance Ends.

- any *treatment*, the sole or primary purpose of which relates to:
  - the change or maintenance of vertical dimension; or
  - the alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service); or
  - bite registration; or
  - bite analysis.
- any *treatment* required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joint or its associated structures.
- athletic mouthguards; replacement of lost or stolen appliances; myofunctional therapy; infection control; oral hygiene instruction; separate charges for acid etch; treatment of jaw fractures; orthognathic surgery; personal supplies; broken appointments; completion of claim forms; exams required by a third party; travel time; transportation costs; professional advice given on the phone.
- *treatment* which:
  - is not *dentally necessary*; or
  - does not have uniform professional endorsement; or
  - is experimental or investigational in nature.
- *treatment* which does not have a reasonably favorable prognosis, as determined by us.
- *treatment* provided primarily for cosmetic purposes.
- *treatment* received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit an assault or felony.
- *treatment* of *injury* arising out of, or in the course of, doing any work for pay, profit, or gain, whether on your or a *covered dependent's* job or any other job.
- *treatment* of an intentionally self-inflicted injury.

- *treatment* performed outside of the United States of America, other than *emergency dental treatment*. However, for such *emergency dental treatment*, the benefits payable shall not exceed the *allowable charge* for the *treatment* at your employer's principal address (shown in the application for insurance) in the USA.

- *treatment* rendered by a dental clinic or similar clinic that is operated by your or your spouse's employer, labor union, or similar group.

- *treatment* of a provider who is a member of your or your spouse's *immediate family*.

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

- *treatment* for which you or your *covered dependent* do not have to pay, except when payment of such benefits is required by law and only to the extent required by law.

- *treatment* that has not been both delivered to and accepted by you or your *covered dependent*.

- *orthodontic treatment*, unless such insurance is provided under the list of covered dental services.

Limited Extension of Benefits After Insurance Ends

If an otherwise non-orthodontic covered dental service is started while you or your *covered dependent* are insured under the *policy* (and after any applicable waiting periods are served), but is completed after the day your or your *covered dependent's* insurance ends, we will pay benefits for otherwise covered dental expenses incurred for that service subject to all of the following rules:

- Benefits are not available to you or your *covered dependent* if, on the day after insurance ends, you or your *covered dependent*, obtain, or are eligible to obtain, dental care coverage under any group or governmental plan;

- Benefits are not available to you or your *covered dependent* if insurance ends because any required premium contributions were stopped while still eligible for insurance;

- Benefits are not available for any *treatment* started after the day your or your *covered dependent's* insurance ends;

- Benefits are payable only in the amount that would have been payable, and subject to the same provisions that would have applied, had your or your *covered dependent's* insurance still been in effect;

- Benefits are payable only if the *treatment* is completed within 31 days after the date your or your *covered dependent*'s insurance ends, unless you or your *covered dependent* become injured or sick after the *treatment* is started and that is the only reason the *treatment* could not be completed during those 31 days. Then, benefits are payable only if the *treatment* is completed before the earlier of:

    - the date 31 days after the first date the *injury* or sickness no longer prevents the *treatment* from being completed; or

    - the date 91 days after the date your or your *covered dependent's* insurance ends;

- We will not pay any benefits for *treatment* which is completed on or after the first date you or your *covered dependent* obtain, or are eligible to obtain dental care coverage under any group or governmental plan.

Limited Benefits for Transfer Insureds' Services Started Under Prior Plan

Our *policy* excludes benefits for services started before the date your or your *covered dependent's* insurance under our *policy* begins. However, if you or your *covered dependent* are a *transfer insured*, we will calculate and pay limited benefits as follows for otherwise-covered dental expenses for services started while you or your *covered dependent* were *continuously covered* under the *prior plan*, but completed while you or your *covered dependent* are insured under our *policy*:

1. Determine the amount (if any) that would have been payable had the service been started and completed while you or your *covered dependent* were *continuously covered* under the p*rior plan*.

2. Determine the amount (if any) that would have been payable had the service been started and completed while you or your *covered dependent* were insured under our *policy*.

3. If either amount is zero, there is no benefit payable under this provision.

4. If both amounts are nonzero, we will prorate the lesser of the two amounts according to our established proration schedule to determine a prorated benefit for each part of the service performed.

   We will pay a prorated benefit only for that part of the service that is performed:

   a) while you or your *covered dependent* are insured under our *policy*; and

   b) after the end of any period during which the *prior plan* extends benefits for the service.

   We will not pay any benefit for any part of the service that is performed either:

   a) before you or your *covered dependent* are insured under our *policy*; or

   b) in any period during which the *prior plan* extends benefits for the service.

Transfer Insureds' Teeth Extracted Under Prior Plan

Under Major Restorations in the Special Limitations provision, items pertain to complete and partial dentures and fixed partial dentures. These items all have references to missing *natural teeth* or to *functioning natural teeth* that have been extracted. For the purpose of applying these limitations where you or your *covered dependent* are a *transfer insured*, a f*unctioning natural tooth* which was extracted while you or your *covered dependent* were *continuously covered* under the *prior plan*, but no earlier than 12 months before the effective date of this *policy*, will be deemed to have been extracted while insured under this *policy*.

COORDINATION OF BENEFITS

Applicability

All of the benefits provided under the *policy* are subject to *this provision.*

Definitions

Allowable expense means any *dentally necessary*, *allowable charge*, at least a portion of which is covered under 1 or more of the *plans* which covers the person:

- for whom claim is made, and
- on whose account payment is legally required.

When a *plan* provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be both an *allowable expense* and a benefit paid.

When benefits are reduced because the person does not comply with the provisions of a plan, the amount of the reduction will not be considered an *allowable expense*. However, any services rendered by a non-HMO/DMO provider for which the HMO/DMO denies payment will be considered an *allowable expense*.

Claim period means a *policy year*. A *claim period* will not start before a person's effective date of insurance under *this plan* nor extend beyond the last day the person is covered under *this plan*.

Medicaid means Title XIX of the Social Security Act of 1965 as amended.

Plan means any plan which provides benefits or services for medical or dental care or *treatment* through:

- group, blanket, or franchise insurance coverage;
- group hospital, medical, or dental service prepayment coverage, group or individual practice or other group prepayment coverage, or group-type coverage through Health Maintenance Organizations (HMOs) or Dental Maintenance Organizations (DMOs);
- a labor-management trusteed plan, union welfare plan, employer or employee organization plan or any other arrangement of benefits, not available to the general public, which is based on membership in a group;
- coverage under government programs or coverage required or provided by any statute, except *Medicaid*. Benefits and services provided by Part A and Part B of *Medicare* are included. If you or a *covered dependent* are eligible for, but not covered under both Part A and Part B of *Medicare* for any reason, the benefits or services that would have been payable if you or the *covered dependent* had been covered, will be included, unless prohibited by state law or regulation; or
- *no-fault motor vehicle coverage* or a Motor Vehicle Financial Responsibility Act, unless prohibited by state law or regulation.

Plan does not include any of the following:

- *school accident coverage*;

- the first $30 per day of benefits under a group or group-type hospital indemnity benefit, written on a non-expense incurred basis;

- *Medicaid*; and does not include a law or *plan* when, by law, its benefits are in excess of those of any private or other non-governmental plan; or

- *no-fault motor vehicle coverage* or a Motor Vehicle Financial Responsibility Act, which, according to its rules, determines its benefits after the benefits of *this plan* have been determined, or any optional *no-fault motor vehicle coverage*.

The term *plan* will be construed separately for each policy, contract, or other arrangement for benefits or services. It will also be construed separately for:

- that part of any policy, contract, or other arrangement which has the right to consider the benefits or services of other *plans* in determining its benefits; and

- that part which does not.

Primary plan means a *plan* whose benefits for health care coverage must be determined without considering the existence of any other *plan*. A *plan* is primary if:

- the *plan* has no order of benefit determination rules, or it has rules which differ from *this provision*; or

- under the order of benefit determination rules, *this plan* determines its benefits first.

School accident coverage means coverage for elementary, high school, or college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

Secondary plan is not a *primary plan*, and may consider the benefits of the *primary plan* and the benefits of any other *plan* which, under the rules of *this provision*, has its benefits determined before those of that *secondary plan*.

This plan means the benefits provided by the *policy*.

This provision means the provision for coordination between the benefits of *this plan* and other *plans*.

Other definitions which may apply to this Coordination of Benefits section appear in the Definitions sections of this *policy*.

Order of Benefit Determination

The rules to establish the order of benefit determination for each *plan* are as follows:

- A *plan* which covers the claimant as an employee, member or subscriber (that is, other than as a dependent) will determine its benefits before a *plan* which covers the claimant as a dependent. However, if the claimant is also a *Medicare* beneficiary, and as the result of the rule established by Title XVIII of the Social Security Act and implementing regulations,

    - the *plan* covering the claimant as a dependent will determine its benefits before *Medicare*; and

- *Medicare* will determine its benefits before the *plan* covering the claimant as other than a dependent (e.g. a retired employee). Then the *plan* covering the claimant as a dependent will determine its benefits before the *plan* covering the claimant as other than a dependent.

- In the event that the claimant is a dependent child whose parents are not divorced or separated, benefits for the child are determined in this order:

  - first, the *plan* which covers the claimant as a dependent child of the parent whose birthdate occurs earlier in a calendar year; and

  - second, the *plan* which covers the claimant as a dependent child of the parent whose birthdate occurs later in the calendar year.

  If both parents have the same birthdate, benefits for the child are determined in this order:

  - first the *plan* which covered the parent longer; and

  - second, the *plan* which covered the other parent for a shorter period of time.

  If the other *plan* does not contain this exact rule regarding dependents, then this rule will not apply, and the rules set forth in the other *plan* will determine the order of benefits.

- In the event that the claimant is a dependent child whose parents are divorced or separated, benefits for the child are determined in this order:

  - When the parent with custody of the child has not remarried,

    - first, the *plan* which covers the child as a dependent of the parent with custody; and

    - second, the *plan* which covers the child as a dependent of the parent without custody; or

  - When the parent with custody of the child has remarried,

    - first, the *plan* which covers the child as a dependent of the parent with custody; and

    - second, the *plan* which covers that child as a dependent of the stepparent; and

    - finally, the *plan* which covers that child as a dependent of the parent without custody; or

  - When the parents have joint custody of the child and the court does not decree which parent is responsible for the health care expenses of the child, then benefits for the child will be determined according to the birthdate rule described above.

- If the specific terms of a court decree that one parent is responsible for the health 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 these terms, then
  - first, the *plan* of parent with financial responsibility; and
  - second, the *plan* of the other parent.

  This does not apply to any *claim 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 both parents are responsible for the health care expenses of the child but gives physical custody of the child to a particular parent, then benefits for the child will be determined according to the birthday rule described above.

- A *plan* which covers the claimant as a laid-off or retired employee, or as a dependent of that person, will determine its benefits after a *plan* covering such claimant as an employee, other than a laid-off or retired employee, or as a dependent of that person.

  If a *plan* does not have a provision regarding laid-off or retired employees, which results in each *plan* determining its benefits after the other, then this rule will not apply.
- When the claimant whose coverage is provided under a federal or state continuation law is also covered under another *plan*, benefits are determined in this order:
  - first, the *plan* which covers the claimant as an employee; and
  - second, the *plan* which covers the claimant under a continuation law.

  If the other *plan* does not have a provision regarding coverage provided under continuation laws, then this rule will not apply.
- When none of the rules described above establish an Order of Benefit Determination, a *plan* which has covered the claimant longer will determine its benefits before a *plan* which has covered that claimant for a shorter period of time.

Effect on Benefits

A *primary plan's* benefits are not reduced because of the existence of another *plan*.

When there are more than two *plans*, *this plan* may be a *primary plan* to one or more other *plans*, and may be a *secondary plan* to a different *plan(s)*.

When *this plan* is a *secondary plan*, benefits payable under *this plan* will be reduced so that when they are added to the benefits payable under all other *plans*, they will not exceed the total *allowable expenses* incurred by you or the *covered dependent* during the *claim period*. Benefits payable under any other *plan* include the benefits that would have been payable had the claim for them been made. Except for Part A and Part B of *Medicare*, you or the *covered dependent* must actually be covered by the other *plans*.

We will exclude the benefits payable under any *plan* in determining the above reduction if:

- that other *plan* contains a provision which requires it to determine its benefits after the benefits of *this plan*, and

- the rules set forth in the Order of Benefit Determination require us to decide the benefits of *this plan* before the other *plan*.

When a reduction is made, each benefit that would have been payable in the absence of *this provision* will be reduced proportionately or in some other manner which we consider fair. The reduced amount will be charged against any benefit limit of *this plan* that may apply.

Right to Receive and Release Necessary Information

A claimant will furnish any information necessary to implement *this provision*. We may release or obtain any information, with respect to the claimant, which we deem necessary. This information may be released to or received from any insurer, other organization, or person. This may be done without the consent of or notice to the claimant. In so acting, we will be free from any liability.

Facility of Payment

When payments which should have been made under *this plan*, by the terms of *this provision*, have been made under any other *plans*, we have the right to pay to any organization making the other payments any amounts we determine are due to satisfy the intent of *this provision*. Any amount we pay in good faith will release us from further liability for that amount.

Recovery of Our Payment

If we pay more than the maximum amount required to satisfy the intent of *this provision* at that time, we have the right to recover the excess paid. We may make recovery from any persons to, or for, or with respect to whom the payments were made, or from any other insurers or organizations. This includes the reasonable cash value of any benefits provided as a service.

CLAIM PROVISIONS

Payment of Benefits

We will pay benefits when we receive all the required proof of covered loss.

To Whom Payable

We will pay dental benefits directly to the providers of dental services for *treatment* of you or your *covered dependents*, if you have assigned your benefits to the providers. We will pay dental benefits to you, if you have not assigned your benefits to the providers. After your death, we have the option to pay any benefits due to your spouse, to the providers of the *treatment*, or to your estate.

Authority

We have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the *policy*. All determinations and interpretations made by us are conclusive and binding on all parties.

Filing a Claim

1. Your *dentist* should send us notice of claim for dental *treatment*. We must have written notice of any insured loss within 30 days after it occurs, or as soon as reasonably possible. You can send the notice to our *home office*, one of our regional claims offices, or to one of our agents. We need enough information to identify you as a *covered person*. If charges for dental *treatment* are expected to be $300 or more, you can receive an estimate of benefits payable before *treatment* begins by following the procedures outlined in the Pre-estimate provision. The *preferred provider* will send notice of all dental expenses incurred under the *preferred provider plan*.

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

3. The time limit for filing a claim is 90 days after the date of the loss.

4. To decide our liability, we may require:

    - itemized bills,
    - proof of benefits from other sources, and
    - proof that you have applied for all benefits from other sources, and that you have furnished any proof required to get them.

    For dental expenses, we may require additional information to determine our liability, including, but not limited to:

    - a complete dental charting indicating extractions, missing teeth, fillings, prosthesis, periodontal pocket depths, orthodontic relationship and the dates work was previously performed, and
    - preoperative x-rays, study models, laboratory and/or hospital reports.

We will ask you to authorize the sources of medical and dental services to release your medical information. If you do not furnish any required information or authorize its release, we will not pay benefits.

If it is not reasonably possible to give proof on time, we will not deny or reduce your claim if you give us proof as soon as reasonably possible.

Physical Exam

We may ask you to be examined as often as we require at any time we choose. We will pay for any exam we require.

Limit on Legal Action

No action at law or in equity may be brought against the *policy* until at least 60 days after you file proof of loss. No action can be brought after the statute of limitations in your state has expired, but, in any case, not after 6 years from the date of loss.

Review Procedure

You must request, in writing, a review of a denial of your claim within 180 days after you receive notice of denial.

You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits, and you may submit written comments, documents, records and other information relating to your claim for benefits.

We will review your claim after receiving your request and send you a notice of our decision within 45 days after we receive your request, or within 90 days if special circumstances require an extension. We will state the reasons for our decision and refer you to the relevant provisions of the *policy*. We will also advise you of your further appeal rights, if any.

Incontestability

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

Any statement made by the *policyholder* or a *covered person* will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the *covered person* or the *beneficiary*.

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

No claim for loss starting 2 or more years after the *covered person's* effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

Overpayment

If a benefit is paid under the *policy* and it is later shown that a lesser amount should have been paid, we will be entitled to a refund of the excess amount from the provider or you.

Subrogation Rights

In the event of any payments for benefits provided to you or a *covered dependent* under the *policy*, we, to the extent of our payments, will be subrogated to all rights of recovery you or your dependent have against any person or organization. You or your dependent will execute and deliver any instruments and papers as may be required and do whatever else is necessary to secure those rights to us and will do nothing after loss to prejudice our rights. If we are precluded from exercising our Subrogation Rights, we may exercise our Right to Reimbursement.

Right to Reimbursement

If you or a *covered dependent*: (a) seek legal recourse (whether by suit, settlement, judgment or otherwise) against any person or organization; and (b) recover payment, in whole or in part, from any such person or organization for the benefits previously paid under the *policy*, then you or your dependent must reimburse us for all payments made under the *policy* for which you have received reimbursement.

Any payments made prior to determination of work-related injury, will be reimbursed upon determination of such payment.

However, the reimbursement will not exceed: (a) the amount of the benefit payments made under the *policy* for which payment is recovered from any person or organization; or (b) the amount recovered from any such person or organization as payment for the same covered dental expenses.

You or your *covered dependents* are not obligated by this provision to seek legal action against any person or organization for which benefits have been paid under the *policy*.

GENERAL PROVISIONS

Entire Contract

The *policy* and the *policyholder's* application attached to it are the entire contract. Any statement made by you or the *policyholder* is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary, but not beyond 3 years before the date the error was found. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about a person is misstated, the facts will determine whether insurance is in effect and in what amount. We will equitably adjust the premium.

Individual Certificates

We will send certificates to the *policyholder* to give to each *covered person*. The certificate will state the insurance to which the person is entitled. It does not change the provisions of the *policy*.

Workers' Compensation

The *policy* is not in place of, and does not affect any state's requirements for coverage by Workers' Compensation insurance.

Agency

Neither the *policyholder*, any employer, any *associated company*, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

HIPAA Notice of Privacy Practices

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

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

I. Our Commitment

Union Security Insurance Company, Union Security Life Insurance Company of New York, and its affiliated prepaid companies* are committed to protecting the personal information entrusted to us by our customers. The trust you place in us when you share your personal information is a responsibility we take very seriously and is the cornerstone of how we conduct our business.

We use the brand name “Assurant Employee Benefits” to associate our products and services and to connect us with the brand of our parent company, Assurant, Inc.

The Health Insurance Portability and Accountability Act (HIPAA) provides us and our affiliates with guidelines and standards to follow when we use or disclose your Protected Health Information (PHI). This new law also gives you, our customer, numerous rights regarding your ability to see, inspect, and copy your PHI. Because our commitment to privacy means complying with all privacy laws, we are providing you this notice outlining our privacy practices. The following information is intended to help you understand what we can and cannot do with your PHI and what your rights are under HIPAA.

II. Our Use and Disclosure of Your PHI

HIPAA allows us to use and disclose your PHI for treatment, payment, and healthcare operations without asking your permission. For instance, we may disclose information to a healthcare provider to assist the provider in properly treating you or a dependent (Treatment). We may disclose certain information to the healthcare provider in order to properly pay a claim or to your employer in order to collect the correct premium amount (Payment). We may disclose your information in order to help us make the correct underwriting decision or to determine your eligibility (Operations).

Other examples of possible disclosures for purposes of healthcare operations include:

- Underwriting our risk and determining rates and premiums for your healthcare plan;
- Determining your eligibility for benefits;
- Reviewing the competence and qualifications of healthcare providers;
- Conducting or arranging for review, legal services, and auditing functions, including fraud and abuse detection and compliance;
- Business planning and development;
- Business management and general administrative duties such as cost-management, customer service, and resolution of internal grievances;
- Other administrative purposes.

We can also make disclosures under the following circumstances without your permission:

- As required by law, including response to court and administrative orders, or to report information about suspected criminal activity;
- To report abuse, neglect, or domestic violence;
- To authorities that monitor our compliance with these privacy requirements;
- To coroners, medical examiners, and funeral directors;
- For research and public health activities, such as disease and vital statistic reporting;
- To avert a serious threat to health or safety;
- To the military, certain federal officials for national security activities, and to correctional institutions;
- To the entity sponsoring your group healthcare plan but only for purposes of enrollment, disenrollment, eligibility or for the purpose of giving the plan sponsor summary information when necessary to help make decisions regarding changes to the plan. If the plan sponsor has certified that its plan documents have been amended to include certain privacy provisions, we may also disclose protected health information to the plan sponsor to carry out plan administration functions that the plan sponsor performs on behalf of the plan;
- To a spouse, family member, or other personal representative if they can show they are assisting in your care or payment of your care and then, without an authorization, only basic information about the status or payment of a claim.

Unless you give us written authorization, we cannot use or disclose your PHI for any reason except as otherwise described in this notice, including uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute the sale of protected health information. We are prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes. You may revoke your written authorization at any time by writing us at the address indicated at the end of this notice.

III. Your Individual Rights

You have the following rights with regard to your Protected Health Information:

- **To Restrict our Use or Disclosure**. You have the right to ask us to limit our use or disclosure of your PHI. While we will consider your request, we are not legally required to agree to the additional restrictions. If we do agree to all or part of your request, we will inform you in writing. We cannot agree to limit any use and disclosure of your PHI if the use or disclosure is required by law.
- **To Access your PHI**. You have the right to view and/or copy your PHI at any time by contacting us. If you want copies of your PHI, or want your PHI in a special format, we may charge you a fee. You have a right to choose what portions of your PHI you want copied and to have prior notice of copying costs. If for some reason we deny your request for access to your PHI, we will provide a written explanation of why your request was denied and explain how you can appeal the denial.
- **To Amend your PHI**. You have the right to amend your PHI, if you believe it is incomplete or inaccurate. Your request must be in writing, with an explanation of why you feel the information should be amended. If we approve your request to amend your PHI,

we will make reasonable efforts to inform others, including people you name, about the amendment to your PHI. We may deny your request for various reasons, for example, if we determine that the information is correct and complete, or if we did not create the information. If we deny your request, we will provide you a written explanation of our decision. We also will explain your rights regarding having your request and our response included with all future disclosures of your PHI.

- **To Obtain an Accounting of our Disclosures**. You have the right to receive a listing from us of all instances in the past six years which we or our business associates have disclosed your PHI for purposes other than treatment, payment, health care operations, or as authorized by you. The accounting will tell you the date we made the disclosure, the name of the person or entity to whom the disclosure was made, a description of the PHI that was disclosed, and the reason for the disclosure. There may be a charge for accounting disclosures if requested more than once a year.

- **To Request Alternative Communications**. You have the right to ask us to communicate with you about your confidential information by a different method or at another location. We will accommodate all reasonable requests.

- **To Be Notified of a Breach**: You will be notified in the event that unsecured protected health information is compromised.

- **To Receive Notice.** You are entitled to receive a copy of this notice that outlines our HIPAA privacy practices. We reserve the right to change these practices and the terms of this notice at any time. We will not make any material changes to our privacy practices without first sending you a revised notice. If you receive this notice on our web site or by electronic mail, you may request a paper copy.

IV. Who to Contact for Questions and Complaints

If you want more information about our privacy practices, wish to exercise any of your rights with regard to your PHI, or have any questions about the information in this notice, please use the contact information below. If you believe we may have violated your privacy rights, or if you disagree with a decision that we made in connection with your PHI, you may file a complaint using the contact information below. You may also submit a written complaint to the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. You may locate the regional office nearest to you by visiting their web site, http://www.hhs.gov/ocr/. We fully support your right to the privacy of your PHI, and will not retaliate in any way if you choose to file a complaint.

Mailing Address: **Assurant Employee Benefits**
Privacy Officer
P.O. Box 419052
Kansas City, MO 64141-6052

Telephone: 800.733.7879
Email: PrivacyOffice.AEB@assurant.com
Web Site: www.assurantemployeebenefits.com

For New York business:

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

Telephone: 888.901.6377
Email: CR4U@assurant.com

V. Organizations Covered by This Notice

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

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

*** In this notice, "we," "us," and "our" refer to Union Security Insurance Company, Union Security Life Insurance Company of New York and the following prepaid dental companies:** DentiCare of Alabama, Inc., Union Security DentalCare of Georgia, Inc., UDC Dental California, Inc., UDC Ohio, Inc., United Dental Care of Arizona, Inc., United Dental Care of Colorado, Inc., United Dental Care of Michigan, Inc., United Dental Care of Missouri, Inc., United Dental Care of New Mexico, Inc., United Dental Care of Texas, Inc., United Dental Care of Utah, Inc., Union Security DentalCare of New Jersey, Inc.

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

SUMMARY PLAN DESCRIPTION

This Summary Plan Description is issued to you in compliance with the Employee Retirement Income Security Act of 1974 (ERISA). Included within this document is your Certificate of Insurance, issued by Union Security Insurance Company in compliance with state law. Your Summary Plan Description does not replace or modify the Master Policy issued by Union Security Insurance Company in any way. The Master Policy is the contract which sets forth the terms and conditions of the benefits the Plan Sponsor chose to provide in its welfare benefit plan. The Master Policy may be amended at any time by agreement between the Plan Sponsor and Union Security Insurance Company. The Master Policy may be terminated at any time by the Plan Sponsor or may be terminated by Union Security Insurance Company for non-payment of premium or for failure to meet the Master Policy's minimum participation requirements. The Plan Administrator has the obligation to prepare, issue, amend and file the Summary Plan Description (SPD) and is solely responsible for its contents.

GENERAL ADMINISTRATIVE PROVISIONS

Name of the Plan:

Earnhardt Management Company

Plan Sponsor:

Earnhardt Management Company
P.O. Box 11836
Tempe, AZ 85284
480.324.8825

Employer I.D. Number:

86-0568174

Type of Plan:

An employee welfare plan providing benefits for:

Dental Insurance
Dental Insurance for Dependents

Plan Number:

PN501 unless another number is assigned by the employer, the Plan Administrator, or on any Form 5500 filed for the Plan.

Effective Date:

The plan, as described in this SPD, became effective on June 1, 2007.

Who Is Eligible:

Eligible Class:

For employee insurance – Each full-time Shareholder or employee of the policyholder or an associated company,

- who is at active work, and
- who is working in the United States of America,

as identified on the policyholder's or our records, except any person enrolled in the Prepaid Dental plan or temporary or seasonal worker.

For dependent insurance - Each person eligible and insured for employee insurance.

Service Requirement: 60 days

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

Full-time means working at least 32 hours per week.

The plan may also cover other persons not included above. Check with the plan administrator.

Plan Administrator:

Earnhardt Management Company
Bonnie Orlowski
P.O. Box 11836
Tempe, AZ 85284
480.324.8825

Type of Administration:

This plan is insured by a contract with Union Security Insurance Company, 2323 Grand Boulevard, Kansas City, Missouri 64108.

Amendment or Termination of Plan:

This plan may be amended or terminated at any time by the Plan Sponsor.

Agent for Service of Legal Process:

Earnhardt Management Company
Bonnie Orlowski
P.O. Box 11836
Tempe, AZ 85284
480.324.8825

Plan Records:

The fiscal records for the plan are kept on a policy year basis ending each September 30.

Cost of Benefits:

The premiums for the Dental Insurance plan for employees are paid for entirely by you.

The premiums for the Dependent Dental Insurance plan are paid for entirely by you.

Your plan includes:

Dental Insurance

Dental Insurance for Dependents

The benefits, limitations and exclusions are described in the Certificate which is found within this Description.

STATEMENT OF ERISA RIGHTS

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

(i) Examine, without charge at the plan administrator's office and at other specified locations such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and, if required, a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

(ii) Obtain, upon written request to the plan administrator, copies of all documents governing the plan, including insurance contracts and collective bargaining agreements, and, if required, copies of the latest annual report (Form 5500 Series) and the updated summary plan description. The administrator may make a reasonable charge for the copies.

(iii) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

(iv) Obtain, without charge, a copy of the plan’s procedures governing qualified medical child support order determinations.

(v) Obtain, automatically and without charge, a copy of your provider network list, if applicable to your plan.

(vi) Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate our plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for welfare benefits is denied in whole or in part you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request certain materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court may decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and legal fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group dental coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights.

The Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of the Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or

2. Your employment ends for any reason other than your gross misconduct.

Your dependent spouse will become a qualified beneficiary if your dependent spouse loses coverage under the Plan because any of the following qualifying events happens:

1. You die;

2. Your hours of employment are reduced;

3. Your employment ends for any reason other than gross misconduct; or

4. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. You die;

2. Your hours of employment are reduced;

3. Your employment ends for any reason other than gross misconduct;

4. You become divorced or legally separated; or

5. The child stops being eligible for coverage under the Plan as a "dependent child".

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, or death of the employee, the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to the Plan Administrator.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Plan Administrator.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, your spouse and dependent children can receive additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to your spouse and dependent children if you die or you get divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

CLAIMS PROCEDURE

The following procedures apply to the extent benefits under your employee benefit plan are insured under a contract issued by Union Security Insurance Company.

PRESENTING A CLAIM

Contact your plan administrator, who will advise you of any forms which are required. These forms should be returned to the Plan Administrator after completion. This Administrator will review them, complete any information concerning eligibility and forward them to Union Security Insurance Company. Time limits for filing the claim and other requirements for notice and proof of loss may be found under the heading, "Filing A Claim".

NOTIFICATION OF DECISION—DENTAL

A decision will be made within 30 days after receipt by Union Security Insurance Company of a properly executed, complete proof of loss, unless special circumstances beyond the control of the Plan require an extension of time for processing the claim. Such an extension of time may not exceed 15 additional days. If the claim is denied in whole or in part, Union Security Insurance Company will provide written notice either directly to you or to the Plan Administrator for delivery to you. The written notice will contain:

1. The specific reason or reasons for the denial;

2. Specific reference to pertinent provisions of the policy upon which the decision is based;

3. A description of any additional material or information needed to perfect the claim and an explanation of why it is necessary; and

4. An explanation of the plan's claim review procedure.

AUTHORITY

Union Security Insurance Company has the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the Policy. All determinations and interpretations made by Union Security Insurance Company are conclusive and binding on all parties.

REVIEW PROCEDURE—DENTAL

You are entitled to a full and fair review of denial of claim. You may make a request to the Plan Administrator or appropriate named fiduciary, if other than the Plan Administrator. The procedure is as follows:

1. The request for review must be in writing and made within 180 days of receipt of written notice of denial;

2. You may review, upon request and free of charge, copies of all documents, records, and other information relevant to the claim for benefits. You have the right to review copies of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making our decision to deny your claim. You have the right to request that we identify all medical experts whose advice was obtained on behalf of the plan;

3. You have the right to submit issues and comments in writing, along with additional documents, records, and other information relating to the claim;

4. If our decision is based on dental necessity or experimental treatment or similar exclusion or limit, you have the right to an explanation of the scientific or clinical judgement for the determination, which will be provided upon request and free of charge.

5. The Plan Administrator will forward the request to Union Security Insurance Company;

6. Union Security Insurance Company will make a decision upon review within 60 days after receipt of the request. The decision on review will be in writing, include the specific reasons for the decision and specific references to the pertinent plan provisions on which the decision is based and be furnished either directly to you or to the Plan Administrator for delivery to you.

ASSURANT
Employee
Benefits

2323 Grand Boulevard
Kansas City, MO 64108

Policy 5299324
Participant 0
Booklet 1
3/12/2015