Solstice PPO Dental Insurance

Certificate of Coverage

FOR: PBC Board of County Commissioners

DENTAL POLICY NUMBER: 11425

ENROLLING GROUP NUMBER: 13000

EFFECTIVE DATE: 01-01-2022

Offered and Underwritten by

Solstice Benefits, Inc.

7901 SW Sixth Court

Plantation, Florida 33324

This Policy Contains Deductible Provisions

Solstice Benefits, Inc.
Dental PPO Certificate of Coverage

This *Certificate of Coverage* ("*Certificate")* lists your rights and obligations as a Covered Person. It is important that you READ YOUR CERTIFICATE CAREFULLY and get to know its terms and conditions.

The Policy may require that you contribute to the required Premiums. You can find information regarding the Premium and your costs from the Enrolling Group.

Solstice Benefits, Inc. ("Solstice") agrees to provide Coverage for Dental Services to Covered Persons of the Enrolling Group. Dental Services are subject to the terms, conditions, exclusions and limitations of the Policy. The Policy is issued based on the Enrolling Group's application and its payment of the required Premium. The Enrolling Group's application is made part of the Policy.

The relationship between Solstice and the Enrolling Group is strictly a contractual relationship. The Enrolling Group is not an agent or employee of Solstice. Solstice and its employees are not agents or employees of the Enrolling Group.

The Policy will take effect on the date specified in the Policy. The Policy will continue in force subject to the timely payment of required Premiums and the termination provisions of the Policy. All Coverage under the Policy will begin at 12:01 a.m. local time at the Enrolling Group's address on the date stated in the Policy. All Coverage will end at 12:00 midnight.

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

The insurance granted by this Certificate provides for DENTAL insurance only.

SOLSTICE BENEFITS, INC.

Leonard A. Weiss

President

Introduction to Your Certificate

You and your Enrolled Dependents can get Coverage under the Policy if you are eligible and the required Premiums have been paid. The “Policy” referred to in this *Certificate* is printed on your Identification ("ID") Card.

Coverage is subject to the terms, conditions, exclusions, and limitations of the Policy. This *Certificate* lists the details of Coverage under the Policy but does not make up the entire Policy. This *Certificate* replaces and supersedes any *Certificate* which Solstice may have previously issued to you. Any future *Certificates* issued to you by Solstice will replace this *Certificate*.

The Enrolling Group expects to keep the Policy for the foreseeable future. The Enrolling Group reserves the right to change or end the Policy at any time. A change or end of the Policy would affect Covered Persons.

How to Use This Certificate

You should read this entire *Certificate*. Many of the details of this *Certificate* and the attached *Schedule of Benefits* are related to each other. Reading just one or two sections may not give you an accurate impression of your Coverage.

Your *Certificate* and *Schedule of Benefits* may be changed by the attachment of Riders and/or Amendments. Please read these documents to see if the provisions in this *Certificate* or *Schedule of Benefits* may have changed.

Many words used in this *Certificate* and *Schedule of Benefits* have special meanings. These words may appear capitalized and are defined for you in *Section 1: Definitions*. If you review *Section 1*, you will have a better understanding of the *Certificate* and the *Schedule of Benefits*.

When we use the words "we," "us," and "our" in this *Certificate*, we are referring to Solstice Benefits, Inc. When we use the words "you" and "your" we are referring to Covered Persons as the term is defined in *Section 1*.

From time to time, the Policy may be amended. When that happens, a new *Certificate*, *Schedule of Benefits,* Rider and/or Amendment will be sent to you. Keep your *Certificate* and *Schedule of Benefits* in a safe place for your reference.

Network and Out-of-Network Benefits

This Certificate describes both types of benefits offered to you under the Policy.

Network Benefits are dental services provided directly by or through a Network Dentist. These benefits apply when you receive Dental Services from a Dentist in our Network. You will usually pay less for Dental Services provided by a Network Dentist. Reimbursement for Network Benefits is based on the Plan Allowance for each Dental Service listed in the *Schedule of Benefits*. You will never be required to pay a Network Dentist an amount for a Dental Service more than the Plan Allowance.

You must always check that the Dentist you have chosen participates in the Network before seeking Dental Services. A dentist’s participation status may change. You can check by calling your Dentist, calling us, or via our website. See the *Contacting Solstice* section below or your ID Card for contact information. If necessary, we can help refer you to a Network Dentist.

Out-of-Network Benefits apply when you choose to get Dental Services from a Dentist who is not in the Network. You will usually pay more for Dental Services at an Out-of-Network Dentist. Reimbursement is based on the Plan Allowance for each Dental Service listed on the *Schedule of Benefits*. The actual charge for a Dental Service provided by an Out-of-Network Dentist may exceed the Plan Allowance. As a result, you may be required to pay an Out-of-Network Dentist an amount for a Dental Service more than the Plan Allowance. In addition, when you get Covered Dental Services from an Out-of-Network Dentist, you must pay the entire bill for the services received and submit a claim for reimbursement.

General - The procedures you must follow to get benefits from Network and Out-of-Network Dentists are listed in *Section 6: Procedures for Obtaining Dental Services*. Network and Out-Of-Network Benefits are subject to payment of any applicable Deductible and Coinsurance unless otherwise stated in *Section 11* or the *Schedule of Benefits*. These sections also describe any limitations. The exclusions listed in *Section 12: General Exclusions* apply to both Network and Out-of-Network Benefits. Unless otherwise stated, the information in all other sections applies to both Network and Out-of-Network Benefits.

Dental Services Covered Under the Policy

Necessary Dental Services are the only services Covered under this Policy. A Dentist performing or prescribing a procedure does not mean that it is Covered under the Policy. Although a procedure or treatment may be the only one available, it does not mean that it is Covered.

As the law permits, we reserve the right to change, interpret, modify, withdraw, add benefits or terminate the Policy in our sole discretion. All changes or amendments to the Policy must be in writing.

We may make changes to the Policy according to the applicable laws giving at least 45 days' notice to the Enrolling Group. These changes may only be made at the renewal date of the Policy.

For purposes of cost or efficiency, we may provide Coverage for services that we would otherwise not cover. The fact that we do so in a case will not in any way require us to do so in similar cases.

We may contract with persons or companies outside of Solstice to provide administrative services for your Policy. The service providers and the nature of the services could change from time to time without prior notice to you. You must cooperate with those service providers in the performance of their duties.

We may need more information from you to check your eligibility and your right to get Coverage for services under the Policy. You are obligated to provide the required information. Failure to cooperate may result in delay or denial of Coverage.

Note About Services

We do not provide Dental Services or practice dentistry. We contract with Dentists to participate in a Network. Dentists in the Network are independent of Solstice and are not employees of Solstice. We make payment to Dentists in the Network through various types of agreements. These agreements may include financial incentives to promote dental care in a cost efficient and effective way. Such financial incentives are not meant to affect your access to Necessary Dental Services.

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

A. You are responsible for choosing your own Dentist.

B. You must decide if any Dentist treating you is right for you. This includes Network Dentists who you choose or Dentists to whom you have been referred.

C. You must decide with your Dentist what care you should receive.

D. Your Dentist is solely responsible for the quality of the care you receive.

We make decisions about eligibility and if a benefit is Covered under the Policy. These decisions are based on your Policy. We are not liable for any act or omission of a Dentist that has or is treating you.

Important Information concerning Medicare

Coverage under the Policy is not meant to add to any coverage given by Medicare. In some cases, Covered Persons enrolled in Medicare may also be enrolled under this Policy. If you are eligible for or enrolled in Medicare, please read the following information.

If you are eligible for Medicare, you must enroll for and maintain coverage under both Medicare Part A and Part B. If you do not enroll in both, and we are the Secondary Plan as described in *Section 8: Coordination of Benefits*, we will pay benefits under the Policy as if you were covered under both Medicare Part A and Part B. This means that you may incur a larger out-of-pocket cost for Dental Services.

If you are enrolled in a *Medicare Advantage* plan, you must follow all rules that require you to seek services from that plan's participating providers. When we are the Secondary Plan, we will pay any benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. If we are the Secondary Plan and you do not follow the rules of the *Medicare Advantage* plan, you may incur a larger out of pocket cost for Dental Services.

Identification ("ID") Card

You should show your ID Card every time you request Dental Services. Your Dentist may ask for your ID Card to verify Coverage and benefit levels.

Contacting Solstice

Throughout this *Certificate,* you will find statements that suggest that you contact us for more information. Whenever you have a question, or need help to resolve a complaint, please contact us **at 1 877.760.2247.** Customer Service representatives are available to take your call during regular business hours, Monday through Friday 8am to 6pm ET. If you leave a voicemail, a representative will return your call within 3 business days.

You may also visit our secure member portal at **www.MySolstice.net** for claim forms, Plan documents, and a listing of Network Dentists.

To contact Customer Service by mail, please use the following address:

Solstice
P.O. Box 19199
Plantation, Florida 33318

To submit claims, please use the following address:

Solstice
P.O. Box 2057
Farmington Hills, Michigan 48333

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Section 1: Definitions

This section defines the terms used throughout this Policy.

Amendment – Any description of additional or alternative provisions attached to the Policy. Amendments are subject to all other terms, conditions, limitations and exclusions of the Policy.

Benefits – Dental Services provided directly by or through a Dentist.

Congenital Anomaly – A physical developmental defect that is present at birth and identified within the first 12 months from birth.

Coinsurance – The charge you must pay for Covered Dental Services under the Policy. A Coinsurance is a percentage of the Plan Allowance. You are responsible for the payment of any Coinsurance directly to the provider of the Dental Services at the time of service or when billed by the provider. You are responsible for the lower amount of the service cost or the Coinsurance.

Coverage or **Covered** - The right to reimbursement for your expenses for covered Dental Services. Coverage is subject to the terms, conditions, limitations and exclusions of the Policy. To be Covered, Dental Services must be provided:

A. When the Policy is in effect;

B. Prior to the date of any individual termination conditions in *Section 4: Termination of Coverage*; and

C. When the recipient is a Covered Person.

For example, Dental Services when a Dentist waives the Coinsurance and/or the Deductible are not Covered.

Covered Person – The Subscriber or Enrolled Dependent meeting all eligibility requirements listed in the Policy while Coverage is in effect. References to you and your Dependents throughout this *Certificate* are references to a Covered Person.

Creditable Coverage - With respect to an individual, coverage of the individual under any of the following:

A. A group health plan, as defined in s. 2791 of the Public Health Service Act;

B. Health insurance coverage; consisting of dental care; provided directly, through insurance, reimbursement, or otherwise and including terms and services paid for as dental care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance contract offered by a health insurance issuer;

C. Part A or B of Title XVIII of the Social Security Act;

D. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under s. 1928;

E. Chapter 55 of Title 10, United States Code;

F. A medical care program of the Indian Health Service or of a tribal organization;

G. The Florida Comprehensive Health Association, or another state health benefits risk pool;

H. A health plan offered under chapter 89 of Title 5, United States Code;

I. A public health plan as defined by rules adopted by the commission, where, to the greatest degree possible, such rules are consistent with U.S. regulations; or,

J. A health benefit plan under s. 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

Deductible – The amount you must pay for Dental Services in a calendar or plan year before we begin paying for benefits that year.

Dental Service or **Dental Procedure** – Dental care or treatment provided by a Dentist to a Covered Person while the Policy is in effect and recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dentist – Any dental practitioner who is duly licensed and qualified under the law of the jurisdiction in which Dental Services are rendered.

Dependent – The Subscriber's legal spouse, or a dependent child of the Subscriber or the Subscriber's spouse. At the Enrolling Group's option, references to the spouse of a Subscriber may include a Domestic Partner. All references to the child will include a natural child, stepchild, adopted child, child Placed for Adoption, or a child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse. The term "Dependent" does not include anyone enrolled as a Subscriber. A person cannot be a Dependent of more than one Subscriber.

The term "Dependent" will not include any dependent child 30 years of age or older, except as stated in *Section 4, sub-section 4.2: Extended Coverage for Handicapped Children*. The term "Dependent" includes a child for whom dental care coverage is required through a Qualified Medical Child Support Order or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order. The term "Dependent" does not include a child who is provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, Pub.L.74-271 (42 U.S.C. s.1395 et seq.) at the time Dependent Coverage begins or will begin.

The Subscriber agrees to reimburse us for any Dental Services provided to the child at a time when the child did not meet these conditions.

Domestic Partner – A person of the opposite or same sex with whom the Subscriber has established a Domestic Partnership.

Domestic Partnership – The relationship between the Subscriber and a Domestic Partner. When Domestic Partners are Covered, proof of Domestic Partnership and financial interdependence must be submitted to us in the form of:

A. Registration as a Domestic Partnership, indicating that neither individual has been registered as a member of another Domestic Partnership within the last 6 months, where such registry exists, or

B. For partners residing where registration does not exist, by an alternative Affidavit of Domestic Partnership, which must be notarized and contain the following information:

    1. The partners are both at least 18 years of age or older and are mentally competent to consent to contract;

    2. The partners are not related by blood in a manner that would bar marriage under state law;

    3. The partners have been living together on a continuous basis prior to the date of the application;

    4. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and

    5. Proof that the partners are financially interdependent. Two or more of the following are collectively enough to establish this:

        a. A joint bank account;

        b. A joint credit card or charge card;

        c. Joint obligation on a loan;

d. Status as an authorized signatory on the partner's bank account, credit card or charge card;

e. Joint ownership of holdings or investments;

f. Joint ownership of residence;

g. Joint ownership of real estate other than residence;

h. Listing of both partners as tenants on the lease of the shared residence;

i. Shared rental payments of residence (need not be shared 50/50);

j. Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;

k. A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);

l. Shared household budget for purposes of receiving government benefits;

m. Status of one as representative payee for the other's government benefits;

n. Joint ownership of major items of personal property (e.g., appliances, furniture);

o. Joint ownership of a motor vehicle;

p. Joint responsibility for child care (e.g., school documents, guardianship);

q. Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);

r. Execution of wills naming each other as executor and/or beneficiary;

s. Designation as beneficiary under the other's life insurance policy;

t. Designation as beneficiary under the other's retirement benefits account;

u. Mutual grant of durable power of attorney;

v. Mutual grant of authority to make health care decisions (e.g., health care power of attorney);

w. Affidavit by creditor or other individual able to testify to partners' financial interdependence; or

x. Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

Eligible Person – A person whose connection with the Enrolling Group meets the eligibility requirements specified in the Policy.

Emergency Condition - A medical or behavioral condition that manifests itself by acute symptoms of enough severity (including severe pain) such that a prudent layperson who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

A. Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;

B. Serious impairment to such person's bodily functions;

C. Serious dysfunction of any organ or part of such person;

D. Serious disfigurement of such person; or

E. A condition described in clause (i), (ii) or (iii) of Section 1867(e)(1)(A) of the Social Security Act.

Emergency Services - Dental screenings, exams, and evaluations provided to determine if an Emergency Condition exists. If it does, the care, treatment, or surgery reasonably necessary to relieve or end the Emergency Condition which is sought or received within 24 hours.

Enrollment Date - The first day of your Coverage under the Policy or, if earlier, the first day of the Waiting Period that must pass before you are eligible to be Covered for benefits.

Enrolled Dependent – A Dependent who is properly enrolled for Coverage under the Policy.

Enrolling Group – The employer or other defined or otherwise legally-constituted group to whom the Policy is issued.

Experimental, Investigational or Unproven Services – At the time we decide about Coverage in a specific case, medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that are:

A. Not approved by the U.S. Food and Drug Administration (FDA) to be marketed for the proposed use;

B. Not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;

C. Subject to review and approval by any recognized review board for the proposed use;

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

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

Initial Eligibility Period – The initial period determined by us and the Enrolling Group during which Eligible Persons may enroll under the Policy.

Maximum Benefit – The maximum amount paid for Covered Dental Services during a calendar or plan year under the Policy or any policy issued by us to the Enrolling Group that replaces the Policy. The Maximum Benefit is stated in *Section 11*.

Medicare – Parts A, B, C, and D of the insurance program established by Title XVIII, United States Social Security Act, as amended.

Member – The Subscriber or Enrolled Dependent meeting all eligibility requirements specified in the Policy while Coverage is in effect. References to you and your Dependents throughout this *Certificate* are references to a Covered Person.

Necessary – Dental Services and supplies which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are:

A. Required to meet the basic dental needs of the Covered Person;

B. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service;

C. Consistent in type, frequency and duration of treatment with guidelines of national clinical research, dental care coverage organizations or governmental agencies accepted by us;

D. Consistent with the diagnosis of the condition;

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

F. Demonstrated through prevailing peer-reviewed dental literature to be either:

1. Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or

2. Safe with promising efficacy:

a. For treating a life-threatening dental disease or condition;

b. In a clinically controlled research setting; and

c. Using a specific research protocol that meets standards equal to those defined by the National Institutes of Health.

For this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one (1) year of the date of the request for treatment.

The fact that a Dentist has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this *Certificate*. The definition of Necessary used in this *Certificate* relates only to Coverage and may differ from that of a Dentist.

Network – A group of Dentists who are subject to a participation agreement in effect with us, directly or through another entity, to provide Dental Services to you. The participation status of Dentists may change from time to time.

Network Benefits – Dental Services provided directly by or through a Dentist in the Network.

Network Dentist – A Dentist who is in the Network.

Open Enrollment Period – A period of time deemed by us and the Enrolling Group during which an Eligible Person may enroll under the Policy after the Initial Eligibility Period.

Orthodontic Lifetime Maximum Benefit – The maximum amount paid for Covered orthodontic Dental Services during a lifetime under the Policy or any policy issued by us to the Enrolling Group that replaces the Policy. The Orthodontic Lifetime Maximum Benefit is stated in *Section 11*.

Out-of-Network Benefits – The Coverage for Dental Services provided by a Dentist who is not in the Network.

Out-of-Network Dentist – A Dentist who is not in the Network.

Placement for Adoption or Placed for Adoption – The assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in that person's residence in compliance with chapter 63, Florida Statutes, in anticipation of the child's legal adoption.

Plan Allowance – The amount used to determine our payment and your Coinsurance for Covered Services. The Plan Allowance is determined as follows:

A. When Covered Services are received from Dentists in the Network, the Plan Allowance is the contracted fee(s) that a Network Dentist has agreed to accept as payment for Dental Services.

B. When Covered Services are received from Dentists not in the Network, the Plan Allowance is based on the contracted fee(s) or the Usual and Customary Charge.

You are responsible for satisfying any applicable Deductible. For Out-Of-Network Benefits you will be responsible for the Dentist's fee, if any, which is greater than the Plan Allowance.

Policy or **Plan** – The Enrolling Group Contract, the Certificate of Coverage, the application of the Enrolling Group, Schedule of Benefits, Riders and/or Amendments that make up the agreement regarding the benefits, exclusions and other terms and conditions between us and the Enrolling Group.

Pre-Existing Condition - A condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the Enrollment Date.

Premium – The periodic fee required for each Covered Person under the terms of the Policy.

Provider – Any dental practitioner who is duly licensed and qualified under the law of the jurisdiction in which Dental Services are rendered.

Rider – Any attached description of Dental Services Covered under the Policy. Dental Services provided by a Rider may be subject to payment of additional Premiums and additional Coinsurance. Riders are subject to all other terms, conditions, limitations and exclusions of the Policy.

Subscriber – An Eligible Person who is properly enrolled for Coverage under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

Usual and Customary Charge – The lesser of:

A. The Provider's normal charge for a similar service or supply; or

B. The Enrolling Group-selected percentile of all charges made by providers of such service or supply in the geographic area where it is received.

Usual and Customary Charges are determined under our reimbursement policy guidelines. Our reimbursement policy guidelines are developed following evaluation and validation of all provider billings by one or more of the following methodologies:

A. As reported by generally recognized professionals or publications.

B. As utilized for Medicare.

C. As determined by dental staff and outside dental consultants.

The percentile used to determine the Maximum Reimbursable Charge is listed in *Section 11*. Additional information about the Usual and Customary Charge, including an estimate of the amount we will pay for a particular Out-of-Network Dental Service, is available upon written request.

Waiting Period - The period that must pass for the individual to be eligible as Covered for benefits under the terms of this Policy.

Section 2: General Provisions

Section 2.1 Entire Policy

The Policy is issued to the Enrolling Group. The Policy consists of the Enrolling Group Dental Insurance Contract ("Enrolling Group Contract"), *Certificate(s)*, *Schedule(s) of Benefits*, the Enrolling Group's application, Subscriber enrollment forms, and any Riders and/or Amendments. These documents make up the entire Policy.

Section 2.2 Limitation of Action

You do not have the right to bring any legal action against Solstice to recover on this Policy, until 60 days after you have properly submitted a request for reimbursement. You may not bring such action after the expiration of the applicable statute of limitations from the time the claim was submitted to us.

Section 2.3 Incontestability

This Policy may not be contested after it has been in force for 2 years after the Policy Effective Date. This Policy may be contested at any time for nonpayment of Premium or fraudulent misrepresentation.

Section 2.4 Initial Term

This Policy will begin at 12:01 a.m. local time on the Effective Date set forth on the cover page of the Enrolling Group Contract. It will extend for an initial term of 12 months thereafter ("Initial Term").

Section 2.5 Renewal Terms

This Policy is renewable at the option of the Enrolling Group at the end of the Initial Term for an additional term of 12 months, and at the end of each 12-month period thereafter ("Renewal Term"). We may modify, change, or amend the Policy, including, but not limited to, changes to Premium rates, for each Renewal Term. We will offer terms of renewal a minimum of 45 days in advance of the Policy's Anniversary Date. Any modifications, changes, or amendments will be subject to the Enrolling Group's acceptance. After an authorized officer of the Enrolling Group signs such modifications, changes, or amendments, they will be made part of the Policy. The renewal Policy will be accepted and approved without the Enrolling Group's signature when the Enrolling Group makes payment to us of the first Premium due for the renewal Policy.

Section 2.6 Payment Terms

The Enrolling Group pays a Premium to us for your participation in the Policy. The amount and term of the Premium is set forth in the Enrolling Group Contract. You may contact your Plan Administrator for information about what part of the Premium may be withheld from your salary. You may also get information about the amount that the Enrolling Group is paying on your behalf.

Section 2.7 Grace Period

This Policy has a 31-day Grace Period. This means that if a required Premium is not paid on or before the date it is due, it may be paid during the following Grace Period. During the Grace Period, the Policy will stay in force. Full payment must be received by the 31st day of the Grace Period. If full payment is not received by the 31st day of the Grace Period, the Policy will automatically terminate on midnight at the end of the third (3rd) business day after the date that the notice of termination is received by the Enrolling Group, notwithstanding any other provision of the Policy to the contrary.

If the Enrolling Group sends us a notice of termination during the Grace Period, the Enrolling Group must pay Premiums for any period that the Policy was in force. This includes the pro rata share of the Grace Period. If the Policy terminates for the Premium not being paid, all unpaid Premiums are due as well as the Premium due for the Grace Period.

Section 2.8 Reinstatement

The Enrolling Group may apply for reinstatement of the Policy that terminated due to failure to pay the Premium by the end of its Grace Period. The Enrolling Group must request reinstatement from us in writing on the Enrolling Group's letterhead. The Enrolling Group must pay all past due Premiums, the current month's Premium, and a reinstatement fee of $25.00 to us. All payments must be submitted within 30 days of the request. If we, in our sole discretion, accept any partial payment of past due Premium, it will be applied to the most overdue Premium on the account.

If we reinstate the Policy, the coverage provided would resume as of the date the Policy was terminated. We may require the Enrolling Group to authorize automatic electronic fund transfers for payment of Premium. If we do not reinstate the Policy, we will notify the Enrolling Group in writing within 45 days of our receipt of the request for reinstatement. If we fail to provide timely notice of our decision to not reinstate the Policy, the Policy will be automatically reinstated. We will refund any Premium not earned that was submitted. The refund will be sent with the denial for reinstatement.

Section 2.9 Changes to the Policy

No change will be made to the Policy unless it is made by an Amendment or a Rider that is signed by an officer of Solstice and of the Enrolling Group. No agent has the authority to change the Policy or waive any of its provisions.

Amendments to the Policy are effective after a 45-day written notice to the Enrolling Group. Riders are effective on the date specified by us. Amendments are subject to all other terms, conditions, limitations and exclusions of the Policy.

Section 2.10 Relationship Between the Parties

The relationship between Solstice and a Dentist in its Network is that of a strictly contractual relationship between independent contractors. The Dentists in the Network are not agents or employees of Solstice. Solstice and our employees are not agents or employees of Dentists in the Network. The relationship between a Dentist in the Network and you are that of Dentist and patient. The Dentist in the Network is solely responsible for the services provided to you.

The relationship between Solstice and the Enrolling Group is strictly a contractual relationship between independent contractors. The Enrolling Group is not an agent or employee of Solstice. Solstice and our employees are not agents or employees of the Enrolling Group.

The relationship between the Enrolling Group and you is that of employer and employee, Dependent or other Coverage classification as explained in the Policy. The Enrolling Group is solely responsible for enrollment and Coverage classification changes. The Enrolling Group is also responsible for the timely payment of the Premiums to us and for notifying you of the termination of the Policy.

Section 2.11 Examination of Covered Persons

In the event of a question or dispute about Coverage for Dental Services, we may reasonably require that a Dentist in the Network examine you. The Dentist in the Network will be acceptable to us. We will pay for the cost of the exam.

Section 2.12 Clerical Error

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

Section 2.13 Notice

We may provide written notice about any aspect of the Policy to an authorized representative of the Enrolling Group. Such written notice will be deemed notice to all affected Covered Persons. The Enrolling Group is responsible for giving notice to you.

Section 2.14 Worker's Compensation Not Affected

The Coverage of this Policy does not replace the need for workers' compensation insurance.

Section 2.15 Conformity with Statutes

Any provision in this Policy that conflicts with applicable state or federal laws and regulations is hereby amended to conform to the minimum requirements of such state or federal laws and regulations.

Section 2.16 Waiver/Estoppel

Nothing in this Policy is waived by any party unless the party claiming the waiver receives the waiver in writing. A waiver of one provision does not constitute a waiver of any other. A failure to enforce any provision of the Policy is not a waiver of such provision. A failure to exercise any option provided in the Policy is not a waiver of such option.

Section 2.17 Headings

The headings, titles and any table of contents in the Policy are to guide you through the policy only. The headings, titles and any table of contents will not affect the meaning or interpretation of the Policy.

Section 2.18 Unenforceable Provisions

Any provision of this Policy that is determined to be illegal or unenforceable by a court of competent jurisdiction, will be modified to agree with the law and the original intent of the Policy to the greatest extent legally permissible. All other provisions will remain in effect.

Section 2.19 Misrepresentations

In the absence of fraud, all statements made by the Enrolling Group or by a Subscriber will be deemed representations and not warranties. Any statement made for the purpose of effecting insurance shall not avoid such insurance or reduce benefits unless contained in a written instrument that is signed by the Enrolling Group, or the Subscriber, a copy of which has been furnished to the Enrolling Group or Subscriber. No misrepresentation shall avoid this Policy or defeat recovery under the Policy unless such misrepresentation was material. No misrepresentation shall be deemed material unless knowledge by us of the facts misrepresented would have led to a refusal to make such contract.

Section 2.20 Non-English Communications

Our Customer Service Department can communicate in multiple languages using a national translation service.

Section 3: Enrollment and Effective Date of Coverage

Section 3.1 Enrollment

Eligible Persons may enroll themselves and their Dependents for Coverage under the Policy during the Initial Eligibility Period or during an Open Enrollment Period. To enroll, an Eligible Person must submit a form provided or approved by us. New Eligible Persons and new Dependents may enroll as described below. If you do not enroll during the Initial Eligibility Period or during an Open Enrollment Period, you must wait 12 months before you can enroll for benefits.

If you enroll for Coverage under the Policy, you must stay enrolled for a period of 12 months. If you choose not to re-enroll at the end of any 12-month period, you must wait 12 months before you can get coverage again.

If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be Covered as an eligible Dependent of the other, but not both. If both parents of an eligible Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

Section 3.2 Effective Date of Coverage

There is never Coverage for Dental Services provided before the Effective Date of the Policy.

Coverage is available on the date that the Eligible Person enrolls if they enroll during the Eligibility Period.

Section 3.3 Coverage for a Newly Eligible Person

Your Coverage will take effect on the date agreed to by the Enrolling Group and us. Your Coverage will only be effective if we receive the required Premium. Your coverage will only take effect if we receive a properly completed enrollment form. This form must be received within 31 days of the date you become eligible.

Section 3.4 Dependent Special Enrollment Period

You, your spouse, or your child, can enroll for Coverage within 30 days of the date you gain a Dependent or become a Dependent through marriage, birth, adoption, placement for adoption, or an award of legal custody. We must receive notice and any Premium payment within 60 days of one of these events,

If you enroll because you lost minimum essential Coverage or because you got married, your Coverage will begin on the first day of the month following your loss of Coverage or marriage.

If you have a newborn or adopted newborn child and we receive notice of such birth within 60 days thereafter, Coverage for your newborn starts at the moment of birth; otherwise Coverage begins on the date on which we receive notice. No additional Premium will be charged for the notice period if notice of the birth or placement of a newborn or newborn adopted child is received within 30 days.

If you gain legal custody of a child or a child is placed with you for adoption in accordance with law, and we receive notice within 30 days of these events, Coverage begins on the date of the event. If you have Individual or Individual and Spouse Coverage, you must also pay any additional Premium for Parent and Child/Children or Family Coverage within 30 days of the custody award in order for Coverage to start on the date custody is awarded. Otherwise, Coverage begins on the date that we receive notice and the Premium payment.

In all other cases, the effective date of your Coverage will depend on when we receive your selection. If your selection is received between the first and fifteenth day of the month, your Coverage will begin on the first day of the following month, as long as your applicable Premium payment is received by then. If your selection is received between the sixteenth day and the last day of the month, your coverage will begin on the first day of the second month, as long as your applicable Premium payment is received by then.

Section 3.5 Special Enrollment Period

A Special Enrollment Period is available during the calendar or plan year for an Eligible Person under the following conditions:

A. At the time of the Initial Eligibility Period or Open Enrollment Period, the Eligible Person had existing dental coverage under another "group health plan," or had "health insurance coverage" as those terms are defined in s. 2791 of the Public Health Service Act; and

B. Such coverage was terminated because of any of the following:

    1. Loss of eligibility, including annulment, legal separation, divorce, death, termination of employment, or reduction in hours of employment.

    2. Termination of employer contributions.

    3. COBRA continuation coverage was exhausted.

If the person had coverage under a prior plan and it was terminated for the following reasons, then a Special Enrollment Period is not available:

A. For cause.

B. For Failure to pay Premiums on a timely basis.

The Policy is only effective if we receive any required Premium and a completed enrollment form within 31 days of the date of coverage under the prior plan terminated.

Section 4: Termination of Coverage

Section 4.1 Conditions for Termination of Coverage

Group-Level Termination

We may terminate or non-renew this Policy upon at least 45 days prior written notice to the Enrolling Group for one or more of the following reasons:

A. The Enrolling Group has not paid Premiums or contributions in accordance with the terms of the Policy, or we have not received timely Premium payments.

B. The Enrolling Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy.

C. The Enrolling Group has not complied with a material provision of the Plan which relates to rules for employer contributions or group participation.

D. The Enrolling Group has not obeyed the rules relating to employer contribution or group participation rules as the law permits.

E. We no longer offer a particular type of coverage in a market.

F. There is no longer any Covered Person who lives, resides, or works in our service area or in the area in which we are authorized to do business.

If we discontinue dental coverage in a market, then we will provide notice of discontinuation to each affected Enrolling Group and Subscriber at least 90 days before the date of discontinuation. We will also offer each affected Enrolling Group the option to purchase all, or in the case of a large group, any other dental insurance coverage currently offered by us in the market.

If we discontinue offering dental coverage in the large group market, then we will provide notice of discontinuation to each affected Enrolling Group and Subscriber at least 180 days before the date of discontinuation.

In exercising the option to discontinue coverage, we will act uniformly without regard to claims experience or any health-status-related factor.

Member-Level Termination

You may lose your status as an Eligible Person, and therefore lose Coverage, based on the following actions by you:

A. Fraud;

B. Material misrepresentation; or

C. Material violation of the terms of the Policy.

We will provide written notice of termination to you 45 days before the termination date. Coverage terminated according to this provision will be done uniformly, without regard to any health status-related factor. You may have continuation of Coverage as described in *Section 5* or as provided under federal and state laws.

Date of Termination

Your Coverage will automatically terminate on the earliest of the following dates:

A. The date the entire Policy is terminated.

B. The date you cease to be an Eligible Person.

C. The date we receive written notice from either you or the Enrolling Group instructing us to terminate Coverage. Your Coverage may terminate on a later date requested in such a notice.

D. The date you retire or are pensioned under the Enrolling Group's Plan. Your Coverage will not terminate if you continue to meet any applicable eligibility requirements and the Enrolling Group's Coverage classifications include retirees or pensioners.

Section 4.2 Extended Coverage for Handicapped Dependent Children

Coverage for an Enrolled Dependent who is incapable of self-sustaining employment by reason of mental retardation, or physical handicap will be continued beyond the age listed under the definition of Dependent provided that:

A. The Enrolled Dependent became so incapable prior to the age at which Dependent Coverage would otherwise terminate;

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

C. Proof of such incapacity and dependence is furnished to us within 31 days of the date the Subscriber receives a request for such proof from us; and

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

Coverage will continue if the Enrolled Dependent is incapacitated and dependent and your Policy remains in effect. Before granting this extension, we may reasonably require that the Enrolled Dependent be examined, at our expense, by a physician designated by us. At reasonable intervals, we may require satisfactory proof of the Enrolled Dependent's incapacity and dependency, including medical exams at our expense. Such proof will not be required more often than once a year. Failure to provide such satisfactory proof within 31 days of the request by us will result in the termination of the Enrolled Dependent's Coverage under the Policy.

Section 4.3 Extended Coverage

A 90-day temporary extension of Coverage will be granted to you on the date of termination if the termination is not voluntary. Coverage will be extended until the earlier of one of the following:

A. 90 days; or

B. The date you become covered under a succeeding policy providing coverage or services for similar dental procedures.

The temporary extension of Coverage will only apply to the following Dental Services:

A. The Dental Procedures were recommended in writing and started by the Dentist while you were Covered under the Policy;

B. The Dental Procedures were procedures for other than routine examinations, prophylaxis, X-rays, sealants, or orthodontic services; and

c. The Dental Procedures were performed within 90 days after your Coverage ceased under the Policy.

All Policy limitations, exclusions, or reductions that would have applied to the specific Dental Procedures had the Coverage not terminated will apply during the extension of Coverage.

Section 4.4 Payment and Reimbursement Upon Termination

Any reimbursement for Dental Services rendered prior to the effective date of termination will not be affected by the termination of your Coverage. Your request for reimbursement must be furnished as required in *Section 7*.

Section 5: COBRA Continuation Coverage Rights

Section 5.1 Introduction

Under federal law, a Subscriber and/or his or her Dependents must be given the opportunity to continue health insurance when there is a Qualifying Event that would result in loss of Coverage under the Plan. A Subscriber and/or his or her Dependents may keep the same coverage under which they were covered on the day before the Qualifying Event occurred, unless they move out of that Plan's coverage area or the Plan is no longer offered. A Subscriber and/or his or her Dependents cannot change coverage options until the next Open Enrollment Period.

Continuation of coverage will be offered to Enrolling Groups subject to the provisions of COBRA. The Subscriber should contact the Enrolling Group's designated Plan Administrator to see if the Subscriber or any of his or her Dependents are entitled to COBRA continuation of coverage.

Solstice is not the Plan Administrator. Solstice will not offer COBRA continuation of coverage if the Plan Administrator fails to follow the rules under federal law. The Plan Administrator has the following responsibilities towards maintenance of the Plan:

A. Notifying the Subscriber and his or her Dependents in a timely manner of their right to choose COBRA continuation coverage; and

B. Notifying Solstice in a timely manner of the choice of the Subscriber and/or the Subscriber's Dependent(s) to continue coverage.

Section 5.2 When COBRA Continuation of Coverage is Available

For a Subscriber and his or her Dependents, COBRA continuation coverage is available for up to 18 months from the date of the following Qualifying Events if the event would result in a loss of Coverage under the Plan:

A. The Subscriber's termination of employment for any reason, other than gross misconduct; or

B. The Subscriber's reduction in work hours.

For a Subscriber's Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following Qualifying Events if the event would result in a loss of Coverage under the Plan:

A. The Subscriber's death;

B. The Subscriber's divorce or legal separation; or

C. For a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Section 5.3 Persons Entitled to COBRA Continuation

In order to be able to elect to COBRA continuation coverage, one must be considered a "Qualified Beneficiary" (as defined by federal law). A Qualified Beneficiary may include any of the following persons who were Covered under the Plan on the day the Qualifying Event occurred:

A. The Subscriber;

B. The Subscriber's Dependent children; or

C. The Subscriber's spouse.

Each Qualified Beneficiary has his or her own right to elect or decline COBRA continuation coverage even if the Subscriber declines or is not eligible for COBRA continuation.

The following individuals are not Qualified Beneficiaries for purposes of COBRA coverage continuation: domestic partners, same sex spouses, grandchildren (unless adopted by the Subscriber), stepchildren (unless adopted by the Subscriber). Although these individuals do not have an independent right to elect COBRA continuation coverage, if the Subscriber elects COBRA continuation coverage for him- or her-self, he or she may also cover his or her Dependents even if they are not considered Qualified Beneficiaries under COBRA. However, such individuals' coverage will terminate when the Subscriber's COBRA continuation coverage terminates. The sections entitled "Secondary Qualifying Events" and "Medicare Extension for Dependents" are not applicable to these individuals.

Section 5.4 Notification Requirements and Election Period for COBRA Continuation

A Qualified Beneficiary who wishes to continue Coverage must request continuation in writing and remit the first Premium payment within the 60-day period following the later of:

A. The date of the Qualifying Event; or

B. The date the Subscriber is sent a notice by first class mail of his or her right to continuation by the Enrolling Group.

The Enrolling Group can charge an additional 2% administrative fee to continue Coverage.

The Qualified Beneficiary must also let the Plan Administrator know when a Secondary Qualifying Event happens. This may extend the time of the continued Coverage.

Section 5.5 Secondary Qualifying Events

If, as a result of a Subscriber's termination of employment or reduction in work hours, the Subscriber's Dependent(s) have elected COBRA continuation coverage, and one or more Dependents experience a Secondary Qualifying Event, then the affected Dependent(s) may elect to extend their COBRA continuation coverage. This extension is for an additional 18 months (seven (7) months if the Secondary Qualifying Event occurs within the Disability Extension period discussed below) for a maximum of 36 months from the initial Qualifying Event. The Secondary Qualifying Event must occur before the end of the initial 18 months of COBRA continuation coverage or within the Disability Extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial Qualifying Event. Secondary Qualifying Events are:

A. The Subscriber's death;

B. The Subscriber's divorce or legal separation; or,

C. For a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Section 5.6 Disability Extension

If, after electing COBRA continuation coverage due to the Subscriber's termination of employment or reduction in work hours, the Subscriber or one of his or her Dependents is determined by the Social Security Administration ("SSA") to be totally disabled under Title II or XVI of the Social Security Act, then the Subscriber and all of his or her Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial Qualifying Event.

To qualify for the Disability Extension, all the following requirements must be satisfied:

A. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual's election of COBRA continuation coverage; and

B. A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, the Plan Administrator must be notified within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all Covered Persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled. All causes for "Termination of COBRA Continuation" listed below will also apply to the period of Disability Extension.

Section 5.7 Medicare Extension for Dependents

When the Qualifying Event is the Subscriber's termination of employment or reduction in work hours, and the Subscriber became enrolled in Medicare (Part A, Part B or both) within the 18 months before the Qualifying Event, then COBRA continuation coverage for the Subscriber's Dependents will last for up to 36 months after the date the Subscriber became enrolled in Medicare. The Subscriber's COBRA continuation coverage will last for up to 18 months from the date of his or her termination of employment or reduction in work hours.

Section 5.8 Termination of COBRA Continuation

COBRA continuation coverage will terminate at the earliest of the following:

A. The end of the COBRA coverage continuation period of 18, 29, or 36 months, as applicable;

B. Failure to pay the required premium within 30 calendar days after the due date;

C. Cancellation of the Enrolling Group's Policy with Solstice;

D. After electing COBRA continuation coverage, a Qualified Beneficiary enrolls in Medicare (Part A, Part B, or both);

E. After electing COBRA continuation coverage, a Qualified Beneficiary becomes covered under another group health plan, unless the Qualified Beneficiary has a condition for which the new plan limits or excludes coverage under a preexisting condition provision. In such case coverage will continue until the earliest of: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or

F. Any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving COBRA continuation coverage (e.g. fraud).

Section 6: Procedures for Obtaining Dental Services

Section 6.1 The Dental Services

You are eligible for Coverage for Dental Services as they are listed in the *Schedule of Benefits* and *Section 11* of this *Certificate.* Such Dental Services must be Necessary and provided by or under the direction of a Dentist. All Coverage is subject to the terms, conditions, exclusions and limitations of the Policy.

Network Benefits

A Network Dentist must provide your Dental Services in order to be considered Network Benefits.

If you enroll for Coverage under the Policy, it does not guarantee Dental Services to be performed by a particular Network Dentist. The list of Network Dentists is subject to change. When a listed Dentist no longer has a contract with us, you must choose among the remaining Dentists in the Network. You are responsible for checking the participation status of the Dentist before receiving Dental Services.

Coverage of Network Benefits may be denied if you fail to verify the participation status of the Dentist.

Coverage for Dental Services is subject to:

A. Payment of Premiums needed for Coverage under the Policy;

B. Payment of any Deductible;

C. Fulfilling any applicable eligibility or benefit waiting period; and

D. Payment of any Coinsurance specified for any Dental Service.

Out-of-Network Benefits

Dental Services not provided by Network Dentists are Out-of-Network Benefits.

Coverage of Out-of-Network Benefits is subject to:

A. Payment of Premiums needed for Coverage under the Policy;

B. Payment of any Deductible; and

C. Fulfillment of any applicable eligibility or benefit waiting period.

You may have to pay all charges at the time services are rendered for Dental Service not provided by a Network Dentist. You must file a claim with us for reimbursement. We reimburse for Covered Dental Services not provided by a Network Dentist. The reimbursement is based on the Plan Allowance.

Emergency Services do not require approval before the Covered Dental Services are rendered. Emergency Services are subject to the terms, conditions, exclusions and limitations of the Policy.

Network Dentists

Solstice has arranged with certain Dentists to participate in a Network. These Network Dentists have agreed to discount their charges for Covered Services.

You will generally pay less for Dental Services provided by a Network Dentist.

We will issue an ID Card to you. You should show this ID Card when Dental Services are rendered. This lets the Dentist know that you are Covered under a Network plan.

Solstice will make a Directory of Network Dentists available to you. You can also call our Customer Service Department to find Dentists in the Network. See the *Contacting Solstice* section in the *Introduction to Your Certificate*, or your ID Card, for contact information. Dentists in the Network must submit a request for payment directly to us. You are responsible for any Coinsurance at the time of service. If a Network Dentist bills you, you should call Customer Service. You do not need to submit claims for Network Dentists for services or supplies.

Section 6.2 Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $300, you should notify us and request a Pre-Treatment Estimate. If your dental exam reveals the need for crowns bridges or prosthetics, you should notify us and request a Pre-Treatment Estimate. All Pre-Treatment Estimates should be completed before any actual Dental Services are rendered. For a Pre-Treatment Estimate, you or your Dentist should send a notice to us via claim form within 20 days of the initial exam. We may request that your Dentist provide us with dental X-rays, study models or other information. This may be necessary to evaluate the treatment plan. This information will also help to determine the extent of the benefit.

We will determine if the proposed treatment is Covered under the Policy and estimate the amount of the payment. The estimate of benefits payable will be sent to you and your Dentist. Pre-Treatment Estimates are subject to all terms, conditions and provisions of the Policy. Dental conditions that can be effectively treated by a less costly procedure will be assigned that less costly benefit.

The Pre-Treatment Estimate is not a guarantee of payment. This procedure lets you know in advance what portion of the expenses will be considered for payment. The Pre-Treatment Estimate will be invalid if the authorized treatment plan has not started within 90 days of the authorization.

Section 7: Reimbursement

Section 7.1 Reimbursement of Covered Dental Services

We will provide reimbursement for Covered Dental Services. These types of reimbursements are subject to the terms, conditions, exclusions and limitations of the Policy.

Section 7.2 Filing Claims for Reimbursement of Covered Dental Services

For Network Benefits, your Network Dentist is responsible for sending a request for reimbursement to us, unless you are responsible for filing the claim directly, as with palliative, or emergency, care.

For Out-of-Network Benefits, you are responsible for sending a request for reimbursement to us for benefits received from an Out-of-Network Dentist.

Notice of Claim

You must send us written Notice of Claim within 20 days after a Covered Dental Service ("Covered Loss") starts, or as soon thereafter as reasonably possible. The Notice of Claim should include your name and the Policy number. If you will be making a request for reimbursement for one of your Covered Dependents, his or her name should also be noted. You should send the Notice of Claim to the second address listed in the *Contacting Solstice* section in the *Introduction to Your Certificate*.

Claim Forms

When we receive the Notice of Claim, we will send you an approved Claim Form for submitting your Proof of Loss. If we do not provide the Claim Form to you within 15 days from the date we receive your Notice of Claim, you may meet Proof of Loss requirements by giving us a written statement and adequate documentation of the Covered Loss within the time stated in the Proof of Loss provision below. This written statement and documentation should contain the following:

A. Your name and address;

B. Patient's name, date of birth, and relationship to Subscriber;

C. Number stated on your ID card;

D. The name, address, tax identification number, and National Producer Identifier (NPI) of the Network Dentist;

E. A diagnosis from the Network Dentist including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim;

F. The radiographs, lab or hospital reports;

G. Casts, molds or study models;

H. An itemized bill that includes the CPT or ADA codes or description of each charge;

I. The date the dental disease began;

J. A statement saying that you are, or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s);

K. A statement certifying that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees charged, and intended to be collected by, the Network Dentist;

L. Your signature and the date.

Alternative Procedure

Instead of filing a Notice of Claim and waiting on us to get back to you, you may get, at any time, a pre-approved Claim Form from our website. See the *Contacting Solstice* section in the *Introduction to Your Certificate* for our website address. You may then submit Proof of Loss in compliance with the requirements below.

Proof of Loss

You must provide written Proof of Loss within 90 days after a Covered Loss begins. If it was not reasonably possible to give written Proof of Loss in the time required, we will not reduce or deny the claim for this reason, if Proof of Loss is filed as soon as reasonably possible. We will deny your claim if you do not provide written Proof of Loss within one (1) year from the date the Covered Loss began, unless you were legally incapacitated.

Late Notice or Submission

Failure to give Notice of Claim or Proof of Loss within the above timeframes will not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

Time of Payment of Claims

After receiving acceptable Proof of Loss, we will pay monthly all benefits then due for Covered Dental Services. We will provide reimbursement within 45 days after receipt of proper Proof of Loss. Benefits will be paid to you unless one of the following occurs:

A. Your signature is on file assigning benefits directly to the Dentist; or

B. You make a written request at the time you submit the claim.

If we contest a claim, or any part of a claim, we will provide written notice to you or your assignee that the claim is contested or denied. We will provide such notice within 45 days after we receive your claim. The notice will identify the contested portion of the claim and give reasons for contesting the claim.

Should we request additional information, and that additional information is provided to us by you or your assignee, we will pay or deny the contested claim within 60 days. In no instance will we take longer than 120 days after receiving a claim, to pay or deny it.

Section 7.3 Limitation of Action

You do not have the right to bring any legal action against Solstice to recover on this Policy, until 60 days after you have properly submitted a request for reimbursement. No such action may be brought after the expiration of the applicable statute of limitations from the time the claim was submitted to us.

Section 8: Coordination of Benefits

Section 8.1 Introduction

This Coordination of Benefits provision ("COB provision") determines an order in which Plans (as defined below) pay their benefits, and permits Secondary Plans to reduce their benefits so that the combined benefits of all Plans do not exceed total Allowable Expenses.

This COB provision provides you with information about:

A. What you need to know when you have coverage under more than one Plan;

B. Definitions specific to coordination of benefit rules; and

C. Order of payment rules.

This COB provision applies when you have dental coverage under more than one benefit Plan. It describes how dental benefits under This Plan will be coordinated with those of any other Plan that provides dental benefits to you. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which you are covered.

Section 8.2 Definitions

The words shown below have special meanings when used in this COB provision. Please read these definitions carefully. Throughout this COB provision, these defined terms appear with their initial letter capitalized.

A. **Allowable Expense –** means any necessary, reasonable, and customary item of expense for dental care that is covered, at least in part, by any of the Plans that cover the person, except where a statute requires a different definition. This includes: (a) deductibles, (b) coinsurance, and (c) copayments. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

   An expense or service that is not covered by any of the Plans is not an Allowable Expense. Examples of other expenses or services that are **not** Allowable Expenses are:

   1. If a person is covered by two (2) or more Plans that compute their benefit payments on the basis of usual and customary charges, any amount in excess of the highest of the usual and customary charges for a specified benefit;

   2. If a person is covered by two (2) or more Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees for a specified benefit; and

   3. The amount the benefit is reduced by the Primary Plan because a person does not comply with the Plan's provisions. For example, if the Plan has reduced its benefit because the person did not get pre-authorization, as required by that Plan, This Plan will not pay the amount of the reduction, because it is not an Allowable Expense.

   If a person is covered by one Plan that computes its benefits or services on the basis of reasonable and customary charges and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements will be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefit.

B. **Claim** – means a request that benefits of a Plan be provided or paid.

C. **Claim Determination Period** – means a calendar or plan year. However, it does not include any part of a year during which a person has no coverage under This Plan, or before the date this COB provision or a similar provision takes effect.

D. **Custodial Parent** – means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

E. **Plan** – means a form of coverage with which coordination of benefits is allowed or required.

1. The term "Plan" includes any of the following that provides benefits or services for dental care or treatment:

    a. Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;

    b. Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;

    c. Group or group-type coverage through a Health Maintenance Organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;

    d. Medicare or other governmental benefits, as permitted by law, except as provided in Paragraph (2)(d) below; and

    e. Dental benefits under group or individual automobile-type contracts.

2. The term "Plan" does not include:

    a. Individual or family insurance contracts or subscriber contracts;

    b. Individual or family coverage through a HMO or under any other prepayment, group practice and individual practice plans;

    c. Blanket school accident-type coverage, or such coverage issued to a substantially-similar group where the policyholder pays the premium;

    d. Medicare supplement policies, Medicaid, and other governmental plans, which, by law, provide benefits that are in excess of those of any private insurance plan or another non-governmental plan; and

    e. Indemnity-type policies, excess insurance policies, health benefit policies limiting coverage to specified illness or accidents.

Each type of coverage listed above is treated separately. If a Plan has two parts and coordination of benefits rules apply only to one of the two, each of the parts is treated separately.

F. **Primary Plan** – means one whose benefits for a person's dental care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if either:

1. The Plan either has no order of benefit determination rules, or it has rules which differ from those explained in this provision; or

2. All Plans which cover the person use the order of benefit determination rules included in this provision and under those rules the Plan determines its benefits first.

There may be more than one Primary Plan (for example, two Plans that have no order of benefit determination rules).

G. **Secondary Plan** – means one which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this section decides the order in which their benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under the rules of this section, has its benefits determined before those of that Secondary Plan.

H. **This Plan –** means the dental benefits provided under the Policy to which this section applies, and which may be reduced on account of the benefits of other Plans. Any other part of the Policy providing health care benefits is separate from This Plan.

Section 8.3 Order of Benefit Determination Rules

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

A. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

B. A Plan that does not contain a COB provision that is consistent with this provision is always primary.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan. If a person is covered by more than one Secondary Plan, the rules explained below decide the order in which Secondary Plan benefits are determined in relation to each other.

D. When all Plans have coordination of benefits provisions, the rules to determine the order of payment are below; the first of these rules that applies is the rule to use:

1. **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is primary. The Plan that covers the person as a dependent is secondary.

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

a. If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, then the Plan of the parent whose birthday, excluding the year of birth, is earlier in the year is primary. If both parents have the same birthday, the Plan that covered either of the parents longer is primary. If a Plan subject to this birthday rule coordinates with an out-of-state Plan that instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

b. If the specific terms of a court decree state that one of the parents must provide health care coverage and the Plan of that parent has actual knowledge of those terms, then that Plan is primary. This rule applies to Claim Determination Periods or plan years starting after the Plan is given notice of the court decree.

c. In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, then the order of benefit determination is:

i. The Plan of the Custodial Parent;

ii. The Plan of the spouse of the Custodial Parent; and

iii. The Plan of the Non-Custodial Parent.

3. **Active or Inactive Employee.** The Plan that covers a person as an active employee, or as that person's dependent, is primary. An active employee is one who is neither laid off nor retired. The Plan that covers a person as a laid off or retired employee, or as that person's dependent, is secondary. If a Plan does not have this rule and as a result the Plans do not agree on the order of benefit determination, this rule is ignored.

4. **Continuation Coverage.** The Plan that covers a person as an employee, member, subscriber, or retired employee, or as that person's dependent, is primary. The Plan that covers a person under a right of continuation provided by federal or state law is secondary. If a Plan does not have this rule and as a result the Plans do not agree on the order of benefit determination, this rule is ignored.

5. **Length of Coverage.** The Plan that covered the person for a longer period of time is primary. To determine the length of time a person has been covered under a Plan, two Plans will be treated as one if the covered person was eligible under the second within 24 hours after the first ended. The start of a new Plan does not include:

    a. A change in the amount or scope of a Plan's benefits;

    b. A change in the entity which pays, provides or administers the Plan's benefits; or

    c. A change from one type of Plan to another (such as, from a single employer plan to that of a multiple employer plan).

    The person's length of time covered under a Plan is measured from the person's first date of coverage under that Plan. If that date is not readily available, the date the person first became a member of the group will be used as the date from which to determine the length of time the person's coverage under the present Plan has been in force.

    If a husband or wife is covered under This Plan as a Subscriber and as an Enrolled Dependent, the dependent benefits will be coordinated as if they were provided under another Plan, this means the Subscriber's benefit will pay first.

6. **Other.** If the above rules do not determine the Primary Plan, the Allowable Expenses will be shared equally among the Plans that meet the definition of Plan under this COB provision; however, This Plan will not pay more than it would have had it been the Primary Plan.

Section 8.4 Effect on the Benefits of This Plan

When This Plan is Primary. When This Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits.

When This Plan is Secondary. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than 100 percent of total Allowable Expenses.

The Secondary Plan will calculate its savings by subtracting the amount that it paid as a Secondary Plan from the amount it would have paid had it been primary. These savings will be recorded as a benefit reserve for the covered person and will be used by the Secondary Plan to pay any Allowable Expenses, not otherwise paid, that are incurred by the covered person during the Claim Determination Period. As each Claim is submitted, the Secondary Plan will:

A. Determine its obligation to pay or provide benefits under its contract;

B. Determine whether overpayment benefit reserve has been recorded for the Covered Person; and

C. Determine whether there are any unpaid Allowable Expenses during that Claim Determination Period.

If there is overpayment benefit reserve, the Secondary Plan will use the Covered Person's recorded benefit reserve to pay up to 100 percent of total Allowable Expenses incurred during the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero. A new benefit reserve must be created for each new Claim Determination Period.

Section 8.5 Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these rules and to determine benefits payable under This Plan and other Plans. This Plan may get the facts it needs from, or give them to, other organizations or persons to apply these rules and determine benefits payable under This Plan and other Plans covering the person claiming benefits.

This Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must provide any facts This Plan needs to apply these rules and determine benefits payable. If a person does not provide the information needed to apply these rules to determine benefits payable, the person’s Claim may be denied.

Section 8.6 Facility of Payment

A payment made under another Plan may include an amount that should have been paid by This Plan. If it does, This Plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by This Plan. This Plan will not have to pay that amount again. As used here, the term "payment made" includes the reasonable cash value of any benefits provided in the form of services.

Section 8.7 Right of Recovery

If the amount of the payments made by This Plan is more than it should have paid under this COB provision, it may recover the excess: (a) from one or more of the persons it has paid or for whom it has paid; or (b) from any other person or organization that may be responsible for the benefits or services provided for the covered person. As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Section 9: Subrogation and Refund of Overpayments

Section 9.1 Subrogation

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. In the event you suffer an injury or illness because of a negligent or wrongful act or omission of a third party, and we provide benefits as a result, we may, in certain circumstances and to the extent permitted by law, be subrogated to all rights, claims or interests that you may have against such party and will automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid under the Policy. This subrogation right extends only to the recovery of the benefits that have been or are obligated to be paid by us.

Where we have a right of reimbursement by law, the amount of the reimbursement will be no more than the amount of the benefits paid by us.

Section 9.2 Refund of Overpayments

If we pay benefits for expenses incurred on your account, you or any other person or organization that was paid must make a refund to us if:

A. All or some of the expenses were not paid by you or did not legally have to be paid by you;

B. All or some of the payment made by us exceeded the benefits under the Policy; or

C. All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, you agree to help us get the refund when requested.

If you, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future benefits that are payable under the Policy. We may also reduce future benefits under any other group benefits plan administered by us for the Enrolling Group. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Section 10: Complaint Procedures

Section 10.1 Initial Complaint Resolution Process

The complaint provision in this *Certificate* may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or complaint procedure.

If you have a concern or question about the provision of Dental Services or benefits under the Policy, you should contact our Customer Service Department. See the *Contacting Solstice* section in the *Introduction to Your Certificate*, or your ID Card for contact information. Customer Service representatives are available to take your call during regular business hours, Monday through Friday from 8am to 6pm EST. At other times, you may leave a message on voicemail. A Customer Service representative will return your call with a resolution within three (3) business days.

If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, or if you do not agree with our resolution, you may submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

Section 10.2 Grievance Resolution Process

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

A. The patient's name and the identification number from your ID card;

B. The date(s) of service(s);

C. The Dentist's name;

D. The reason you believe the claim should be paid; and

E. Any new information to support your request for claim payment.

We will notify you of our decision regarding our reconsideration of your complaint within 30 days of receiving it. If you are not satisfied with our decision, you have the right to take your complaint to the Florida Department of Financial Services.

Section 10.3 Appeal Process

If you disagree with our grievance resolution, you may appeal our decision within 60 days. We will resolve the appeal within 60 days.

If you still do not agree with our resolution, you can make a second appeal within 60 days. We will appoint a committee to resolve or recommend the resolution of your complaint. If your complaint is related to clinical matters, we may consult with, or seek the participation of, medical and/or dental experts as part of the resolution process.

The committee will advise you of the date and place of your complaint hearing. You may attend in person, or by phone. The hearing will be held, and the issue resolved within 60 days following receipt of your request by us. The committee will review testimony, explanation or other information that it decides is necessary for a fair review of the complaint.

We will send you written notification of the decision. If you are not satisfied with our decision, you have the right to take your complaint to the Florida Department of Financial Services.

Section 10.4 Exceptions for Emergency Situations

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

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

B. We will notify you of the decision by the end of the next business day after your complaint is received, unless more information is needed.

C. If we need more information from your Dentist to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

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

If you are not satisfied with our decision, you have the right to take your complaint to the Florida Department of Financial Services.

Section 10.5 Appeals to the State

You have the right to contact the Florida Department of Financial Services for assistance at any time. You may reach the Florida Department of Financial Services by any of the following means:

A. Address: Florida Department of Financial Services, 200 East Gaines Street, Tallahassee, Florida 32399;

B. Phone: 1-800-342-2762; or

C. Internet: www.myfloridacfo.com.

Section 11: Covered Dental Services

Section 11.1 Introduction

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

A. Necessary;

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

C. Not excluded as described in Section 12: General Exclusions;

D. Not a Non-Covered Service as identified below; and

E. Listed in the *Schedule of Benefits*.

Waiting Periods, Deductibles, Maximum Benefits, and payment of any Coinsurance as described below and/or in the *Schedule of Benefits* apply to all Dental Services.

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

Section 11.2 Payment of Network Benefits

The amount you pay as Coinsurance for Covered Dental Services is determined as a percentage of the Plan Allowance rather than a percentage of the billed charge. Our Plan Allowance is usually lower than the billed charge.

A Network Dentist cannot charge for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary, the Network Dentist may charge you. Such charges will not be considered Covered and will not be paid by us.

Section 11.3 Payment of Out-of-Network Benefits

The Out-of-Network Plan Allowance is based on the Usual and Customary Charge. The percentile used to determine the Usual and Customary Charge is 80%.

Section 11.4 Deductible

The Network Deductible is $50 per calendar year for individuals, and $150 per calendar year for families. The Out-of-Network Deductible is $100 per calendar year for individuals, and $300 per calendar year for families. Expenses incurred for either Network or Out-of-Network services will be used to satisfy both the Network and Out-of-Network Deductibles.

The Network Deductible does not apply to DIAGNOSTIC SERVICES and PREVENTIVE SERVICES. The Out-of-Network Deductible does not apply to DIAGNOSTIC SERVICES and PREVENTIVE SERVICES.

The Deductible for benefits applies to any combination of the following Dental Services listed on the *Schedule of Benefits*: BASIC SERVICES, ENDODONTICS, PERIODONTICS, ORAL SURGERY, ADJUNCTIVE SERVICES, MAJOR RESTORATIVE SERVICES, IMPLANTS, FIXED PROSTHETICS, and REMOVABLE PROSTHETICS.

Section 11.5 Maximum Benefit

The Network Maximum Benefit is $1,500 per person per calendar or plan year. The Out-of-Network Maximum Benefit is $1,000 per person per calendar or plan year. The sum of all Network and Out-of-Network benefits will not exceed the Maximum Benefit.

Maximum Benefit applies to any combination of the following Dental Services listed on the *Schedule of Benefits*: DIAGNOSTIC SERVICES, PREVENTIVE SERVICES, BASIC SERVICES, ENDODONTICS, PERIODONTICS, ORAL SURGERY, ADJUNCTIVE SERVICES, MAJOR RESTORATIVE SERVICES, FIXED PROSTHETICS, and REMOVABLE PROSTHETICS.

Increasing Calendar Year Maximum

Note: The Increasing Calendar Year Maximum option described below will ONLY be in effect should the Enrolling Group select this option upon initial enrollment.

Please refer to the following Increasing Calendar Year Maximum chart to determine the applicable Carryover Amount, Network Bonus, and Increase Limit based on your Maximum Benefit.

Increasing Calendar Year Maximum					
Maximum Benefit	**Claim Threshold**	**Carryover Amount**	**Network Bonus**	**Increase Limit**	**Maximum Benefit Limit**
$500	$250	$125	$100	$500	$1,000
$1,000	$500	$250	$100	$1,000	$2,000
$1,250	$500	$250	$100	$1,250	$2,500
$1,500	$750	$400	$100	$1,500	$3,000
$2,000	$1,000	$500	$100	$1,500	$3,500
$2,500	$1,250	$600	$100	$1,875	$4,375
$3,000	$1,500	$700	$100	$2,250	$5,250

You may be eligible to carryover a portion of your unused Maximum Benefit if:

A. You have submitted a claim for a Covered Dental Service incurred during the preceding calendar year; and

B. The reimbursements for all Covered Dental Services incurred in the preceding calendar year did not exceed the applicable Claim Threshold in the above chart.

In addition to the Carryover Amount, you may also be eligible for a Network Bonus if:

A. You qualified for a Carryover Amount; and

B. You received all Covered Services during the calendar year from a Network Dentist.

The Carryover Amount and the Network Bonus are your Increasing Maximum Balance and may accumulate from one year to the next. However, your Increasing Maximum Balance may not exceed the Increase Limit.

The Increasing Maximum Balance pays for Covered Dental Services after you have reached your Maximum Benefit in a calendar year. However, you cannot use the Increasing Maximum Balance for orthodontic services.

Eligibility for the Carryover Amount and Network Bonus will be established or reestablished at the time the first claim is received during the calendar year. In order to properly calculate the Carryover Amount, claims should be submitted timely in accordance with the proof of loss provision found within *Section 7: Reimbursement*.

You have the right to request review of prior Increasing Maximum Balance calculations. The request for review must be within 24 months from the date the Increasing Maximum Balance was established.

If your Plan has different Network versus out-of-network Benefit Maximums, we base the Carryover Amount on the out-of-network Benefit Maximum.

Your Increasing Maximum Balance will be forfeited if:

A. You terminate Coverage for six-month period;

B. Your Enrolling Group Terminates the Policy; or

C. Your Enrolling Group changes to a Solstice Policy without an Increasing Calendar Year Maximum option.

Section 11.6 Orthodontic Lifetime Maximum Benefit

The Orthodontic Lifetime Maximum Benefit is $1,000 per person per lifetime.

Section 11.7 Pregnancy Waiver

Coinsurance, Deductible, Waiting Period and Maximum Benefit provisions are waived in a Covered Person's 2nd or 3rd trimester of pregnancy for the following services: prophylaxis, scaling and root planing, periodontal maintenance, full mouth debridement.

Section 11.8 Limitations and Services Not Covered

Alternative Benefit

Where two or more professionally acceptable Dental Services or Procedures for a dental condition exist, we base reimbursement on the least costly treatment alternative. If you and your Dentist agreed on a treatment which is costlier than the treatment on which the Policy benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered under the Policy. In addition, a pre-treatment estimate is advised for any service estimated to cost over $300; please consult your Dentist.

Pre-existing Condition

A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the Enrollment Date.

Expenses for these conditions will not be eligible for consideration, unless incurred after you have been insured for 12 consecutive months from your Effective Date of Coverage.

We will not exclude Coverage for a period in excess of 12 months following the Enrollment Date of this Coverage. We will credit the time you were previously covered under Creditable Coverage, if the previous Creditable Coverage was continuous to a date not more than 63 days before the Enrollment Date in this Coverage, exclusive of any Waiting Period under this Policy.

Genetic information will not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such information.

The pre-existing condition limitation provision will not exclude Coverage if you are:

A. An individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under Creditable Coverage;

B. A child who is adopted or Placed for Adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or Placement for Adoption, is covered under Creditable Coverage; or

C. Pregnant.

Other Limitations

Other Limitations are listed in the *Schedule of Benefits*.

Non-Covered Services

The following is a list of services that are not Covered unless otherwise stated in the *Schedule of Benefits* or in a Rider and/or Amendment to the Policy:

A. Dental Services that are not Reasonable and/or Necessary.

B. Hospital or other facility charges.

C. Reconstructive surgery to the mouth or jaw.

D. Procedures not directly associated with dental disease, including preventive measures that guard against disease or infection not currently present.

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

F. Procedures that are considered Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a condition will not result in Coverage if the procedure is considered Experimental, Investigational or Unproven in the treatment of that particular condition.

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

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

I. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal.

J. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

K. If previously submitted for payment under the Plan within 60 months of initial or subsequent placement, replacements of: (a) complete or partial dentures, (b) fixed bridgework, or (c) crowns. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

L. If damage or breakage was directly related to provider error, replacements of: (a) complete or partial dentures, (b) fixed bridgework, or (c) crowns. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

M. Temporomandibular joint (TMJ) services, upper and lower jaw bone surgery, including that related to the TMJ, and orthognathic surgery, or jaw alignment.

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

O. Expenses for dental procedures begun before you become enrolled under the Policy.

P. Prosthodontic restoration that is fixed or removable for complete oral rehabilitation, and procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

Q. Attachments to conventional removable prosthesis or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

R. Incision and drainage of abscess, if the involved tooth is extracted on the same date of service.

S. Occlusal guards used as safety items or for sports-related activities.

T. Placement of fixed or partial dentures for the sole purpose of achieving periodontal stability.

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

V. Acupuncture, acupressure, and other forms of alternative treatment, whether used as anesthesia.

W. Services for which the Coinsurance and/or the Deductible are waived by the provider.

X. Crowns, inlays, cast restorations, or laboratory prepared restorations when the tooth/teeth may be restored with an amalgam or composite resin filling.

Y. Appliances, inlays, cast restorations, or other laboratory prepared restorations when used primarily for the purpose of splinting.

Z. Any charges related to histological review of diagnostic biopsy, material, or specimens submitted to a pathologist or pathology lab.

AA. Any charges related to infection control, denture duplication, oral hygiene instructions, radiograph duplication, charges for claim submission, equipment or technology fees, exams required by a third party, personal supplies, or replacement of lost or stolen appliances.

BB. Replacement of missing natural teeth lost before the effective date of coverage are not covered.

CC. Any Dental Services or Procedures not listed in the *Schedule of Benefits*.

Section 11.9 Credit for Prior Coverage

If you become Covered due to a mid-year plan change, you will need to submit evidence of any payment towards your prior policy's Deductible. If you had prior Orthodontic coverage under another policy, you will need to submit evidence of any payments towards your prior policy's Deductible. You will also need to submit evidence of the total benefits paid under your prior policy in order to have the amount applied to this Policy's applicable Maximum(s).

Section 12: General Exclusions

This Policy excludes Coverage for Dental Services, unless otherwise listed in the *Schedule of Benefits* or in a Rider and/or Amendment, as follows:

A. Illness, accident, treatment or medical condition arising out of:

   1. War or act of war (whether declared or undeclared); participation in a felony, riot or insurrection;

   2. Service in the Armed Forces or auxiliary units thereto;

   3. Suicide, attempted suicide or intentionally self-inflicted injury;

   4. Aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; and

   5. With respect to blanket insurance, interscholastic sports.

B. Cosmetic surgery, except that cosmetic surgery will not include reconstructive surgery when such service is related to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

C. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any State or Federal workers' compensation, employers' liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the Covered Person's immediate family; and services for which no charge is normally made;

D. Services provided while the Covered Person is outside the United States, its possessions or the countries of Canada and Mexico are not Covered unless required as an Emergency Service.

E. Any loss to which a contributing cause was your commission of or attempt to commit a felony or to which a contributing cause was you being engaged in an illegal occupation.

F. Any loss sustained or contracted in as a result of your being intoxicated (as defined by the laws of the jurisdiction in which the loss occurred) or under the influence of any narcotic unless administered on the advice of a physician.

SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION & LIMITATION	NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied.	OUT-OF-NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Plan Allowance.
DIAGNOSTIC SERVICES		
Bacteriologic Cultures	100%	90%
Viral Cultures	100%	90%
Intraoral Bitewing Radiographs Limited to 1 series of films per consecutive 12 months.	100%	90%
Panorex Radiographs or Intraoral - Complete Series (including bitewings) Limited to 1 time per consecutive 36 months. Vertical bitewings cannot be billed in conjunction with a complete series.	100%	90%
Oral/Facial Photographic Images Limited to 1 time per consecutive 36 months.	100%	90%
Diagnostic Casts Limited to 1 time per consecutive 24 months.	100%	90%
Extraoral Radiographs Limited to 2 films per consecutive 12 months.	100%	90%
Intraoral Periapical Radiographs	100%	90%
Pulp Vitality Tests Limited to 1 charge per visit, regardless of how many teeth are tested.	100%	90%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied.	OUT-OF-NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Plan Allowance.
Intraoral Occlusal Film	100%	90%
Periodic Oral Evaluation Limited to 2 times per consecutive 12 months.	100%	90%
Comprehensive Oral Evaluation Limited to 1 time per Dentist per consecutive 36 months. Not Covered if done in conjunction with other exams.	100%	90%
Limited or Detailed Oral Evaluation Only 1 exam is Covered per date of service.	100%	90%
Comprehensive Periodontal Evaluation - new or established patient Limited to 1 time per Dentist per consecutive 36 months. Not Covered if done in conjunction with other exams.	100%	90%
Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures. Limited to 1 time per consecutive 12 months.	100%	90%
PREVENTIVE SERVICES		
Space Maintainers Limited to Covered Persons under the age of 16 years, 1 time per consecutive 60 months. Benefit	100%	90%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied.	OUT-OF-NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Plan Allowance.
includes all adjustments within 6 months of installation.		
Dental Prophylaxis Limited to two (2) prophylaxis in any 12 consecutive months, to a maximum of two (2) total prophylaxis and/or periodontal maintenance cleanings in any 12 consecutive months.	100%	90%
Fluoride Treatments - child Limited to Covered Persons under the age of 16 years, and limited to 1 time per consecutive 12 months.	100%	90%
Sealants Limited to Covered Persons under the age of 16 years and to 1 time per first or second unrestored permanent molar every consecutive 36 months.	100%	90%
BASIC SERVICES (including, but not limited to, ORAL SURGERY, ADJUNCTIVE SERVICES)		
Re-Cement Space Maintainers Limited to 1 time per appliance per consecutive 6 months after initial insertion.	100%	90%
Amalgam Restorations Multiple restorations on one surface will be treated as a single filling.	80%	70%
Composite Resin Restorations Multiple restorations on one surface will be treated as a single filling.	80%	70%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied.	OUT-OF-NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Plan Allowance.
Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core Limited to those performed more than 12 months after the initial insertion.	80%	70%
MAJOR RESTORATIVE SERVICES (including, but not limited to, FIXED PROSTHETICS, REMOVABLE PROSTHETICS, ENDODONTICS, PERIODONTICS, IMPLANTS) Major Restorative services are subject to satisfaction of any Deductible, and payment of any applicable Coinsurance. REPLACEMENT of crowns, bridges, and fixed or removable prosthetic appliances, if inserted prior to plan coverage, are covered after the patient has been eligible under the plan for 12 continuous months, notwithstanding any other limitations. REPLACEMENT of missing natural teeth lost prior to the effective date of coverage are covered only after the patient has been eligible under the plan for 12 continuous months.		
ENDODONTICS		
Apexification Limited to 1 time per root per lifetime.	50%	40%
Apicoectomy and Retrograde Filling Limited to 1 time per root per lifetime.	50%	40%
Hemisection Limited to 1 time per tooth per lifetime.	50%	40%
Root Canal Therapy - Anterior Limited to 1 time per tooth per lifetime.	50%	40%
Root Canal Therapy - Posterior Limited to 1 time per tooth per lifetime.	50%	40%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied.	OUT-OF-NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Plan Allowance.
Retreatment of Previous Root Canal Therapy Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 18 months.	50%	40%
Root Resection/Amputation Limited to 1 time per root per lifetime.	50%	40%
Therapeutic Pulpotomy Limited to 1 time per primary or secondary tooth per lifetime.	50%	40%
Pulpal Therapy (resorbable filling) - Anterior or Posterior, Primary Tooth (excluding final restoration) Limited to 1 time per tooth per lifetime.	50%	40%
Pulp Caps - Direct/Indirect – excluding final restoration Not covered if utilized solely as a liner or base underneath a restoration.	50%	40%
Pulpal Debridement, Primary and Permanent Teeth Limited to 1 time per tooth per lifetime. This procedure is not to be used when endodontic services are done on same date of service.	50%	40%
PERIODONTICS		
Crown Lengthening	50%	40%
Gingivectomy/Gingivoplasty	50%	40%

BENEFIT DESCRIPTION & LIMITATION	**NETWORK COINSURANCE** is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied.	**OUT-OF-NETWORK COINSURANCE** is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Plan Allowance.
Limited to 1 time per quadrant or site per consecutive 36 months.		
Gingival Flap Procedure Limited to 1 time per quadrant or site per consecutive 36 months.	50%	40%
Osseous Graft Limited to 1 time per quadrant or site per consecutive 36 months.	50%	40%
Osseous Surgery Limited to 1 time per quadrant or site per consecutive 36 months.	50%	40%
Guided Tissue Regeneration Limited to 1 time per quadrant or site per consecutive 36 months.	50%	40%
Soft Tissue Surgery Limited to 1 time per quadrant or site per consecutive 36 months.	50%	40%
Periodontal Maintenance Limited to two (2) periodontal maintenance in any 12 consecutive months, to a maximum of two (2) total prophylaxis and/or periodontal maintenance procedures in any 12 consecutive months.	50%	40%
Full Mouth Debridement Limited to 1 time per consecutive 36 months.	50%	40%
Provisional Splinting Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include	50%	40%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied.	OUT-OF-NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Plan Allowance.
use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.		
Scaling and Root Planing Limited to 1 time per quadrant per consecutive 24 months.	50%	40%
Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report. Limited to 1 site per quadrant or 4 sites total per 12 consecutive months for refractory pockets, not in conjunction with scaling or root planing, by report.	50%	40%
ORAL SURGERY		
Alveoloplasty	50%	40%
Biopsy Limited to 1 biopsy per site per visit.	50%	40%
Frenectomy/Frenuloplasty	50%	40%
Surgical Incisions Limited to 1 time per site per visit.	50%	40%
Removal of a Benign Cyst/Lesions Limited to 1 time per site per visit.	50%	40%
Removal of Torus Limited to 1 time per site per visit.	50%	40%
Root Removal, Surgical	50%	40%

BENEFIT DESCRIPTION & LIMITATION	**NETWORK COINSURANCE** is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied.	**OUT-OF-NETWORK COINSURANCE** is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Plan Allowance.
Limited to 1 time per tooth per lifetime.		
Simple Extractions Limited to 1 time per tooth per lifetime.	80%	70%
Surgical Extraction of Erupted Teeth Limited to 1 time per tooth per lifetime.	50%	40%
Surgical Extraction of Impacted Teeth Limited to 1 time per tooth per lifetime.	50%	40%
Surgical Access, Surgical Exposure, or Immobilization of Unerupted Teeth Limited to 1 time per tooth per lifetime.	50%	40%
Primary Closure of a Sinus Perforation Limited to 1 time per tooth per lifetime.	50%	40%
Placement of Device to Facilitate Eruption of Impacted Tooth Limited to 1 time per tooth per lifetime.	50%	40%
Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report Limited to 1 time per tooth per lifetime.	50%	40%
Vestibuloplasty	50%	40%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied.	OUT-OF-NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Plan Allowance.
Limited to 1 time per site per consecutive 60 months.		
Bone Replacement Graft for Ridge Preservation - per site Limited to 1 time per site per lifetime. Not Covered if done in conjunction with other bone graft replacement procedures.	50%	40%
Excision of Hyperplastic Tissue or Pericoronal Gingiva Limited to 1 time per site per consecutive 36 months.	50%	40%
Tooth Reimplantation and/or Transplantation Services Limited to 1 time per tooth per lifetime.	50%	40%
Oroantral Fistula Closure Limited to 1 time per site per visit.	50%	40%
ADJUNCTIVE SERVICES		
Analgesia Covered when Necessary for one of the following reasons; toxicity to local anesthesia, mental retardation, Alzheimer's, spastic muscle disorders.	50%	40%
Desensitizing Medicament	50%	40%
General Anesthesia Covered when Necessary for one of the following reasons: toxicity to local anesthesia, mental retardation, Alzheimer's, spastic muscle disorders.	50%	40%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied.	OUT-OF-NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Plan Allowance.
Local Anesthesia Not Covered in conjunction with operative or surgical procedure.	50%	40%
Intravenous Sedation and Analgesia Covered when Necessary for one of the following reasons; toxicity to local anesthesia, mental retardation, Alzheimer's, spastic muscle disorders.	50%	40%
Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report Limited to 1 time per visit.	50%	40%
Occlusal Adjustment	50%	40%
Occlusal Guard Reline and Repair Limited to relining and repair performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	50%	40%
Occlusion Analysis - Mounted Case Limited to 1 time per consecutive 60 months.	50%	40%
Palliative Treatment Covered as a separate benefit only if no other services, other than exam and radiographs, were done on the same tooth during the visit.	100%	90%
Consultation (diagnostic service provided by dentists other than practitioner providing treatment.) Not Covered if done with exams or professional visit.	100%	90%

BENEFIT DESCRIPTION & LIMITATION	**NETWORK COINSURANCE** is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied.	**OUT-OF-NETWORK COINSURANCE** is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Plan Allowance.
Gold Foil Restorations Multiple restorations on one surface will be treated as a single filling.	50%	40%
Occlusal Guards Limited to 1 guard per 60 consecutive months and only covered if prescribed to control habitual grinding.	50%	40%
Coping Limited to 1 time per tooth per 60 consecutive months. Not Covered if done at the same time as a crown on same tooth.	50%	40%
Inlays/Onlays – Temporary Crown/Crowns – Restorations/Retainers/ Abutments Limited to 1 time per tooth per 60 consecutive months. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50%	40%
Pontics Limited to 1 time per tooth per 60 consecutive months.	50%	40%
Retainer-Cast Metal for Resin Bonded Fixed Prosthesis Limited to 1 time per tooth per 60 consecutive months.	50%	40%
Pin Retention Limited to 2 pins per tooth; not covered in addition to cast restoration.	50%	40%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied.	OUT-OF-NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Plan Allowance.
Post and Cores Covered only for teeth that have had root canal therapy.	50%	40%
Sedative Filling Covered as a separate benefit only if no other service, other than X-rays and exam, were done on the same tooth during the visit.	50%	40%
Stainless Steel Crowns Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	50%	40%
IMPLANTS		
Surgical Services Surgical placement of implant body (endosteal) & interim implant body, both eposteal and transosteal. Implant removal, by report. Limited to one (1) time per tooth per 60 consecutive months.	50%	40%
Supporting Structures Prefabricated abutment, and custom abutments Limited to one (1) time per tooth per 60 consecutive months. Covered only when evidence of implant body surgically placed.	50%	40%
Single Crowns, Abutment Supported Porcelain ceramic, porcelain to metals, cast metals, titanium	50%	40%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied.	OUT-OF-NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Plan Allowance.
One (1) per 60 consecutive months if the previous crown is not serviceable and cannot be repaired.		
Fixed Partial Denture, Abutment Supported Porcelain/ceramic FPD, porcelain fused to metals FPD, cast metals FPD, titanium crown FPD One (1) per 60 consecutive months if the previous crown is not serviceable and cannot be repaired.	50%	40%
Other Implant Services Repair prosthesis, repair abutment, implant removal Covered only when administered by a different provider.	50%	40%
FIXED PROSTHETICS		
Fixed Partial Dentures (Bridges) Limited to 1 time per tooth per 60 consecutive months.	50%	40%
REMOVABLE PROSTHETICS		
Full Dentures Limited to 1 per 60 consecutive months. No additional allowances for precision or semi-precision attachments.	50%	40%
Partial Dentures Limited to 1 per 60 consecutive months. No additional allowances for precision or semi-precision attachments.	50%	40%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied.	OUT-OF-NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Plan Allowance.
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 36 months.	50%	40%
Tissue Conditioning - Maxillary or Mandibular Limited to 1 time per consecutive 36 months.	50%	40%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 time per consecutive 6 months.	50%	40%
ORTHODONTICS Orthodontic services are subject to satisfaction of any applicable Deductible, and payment of any applicable Coinsurance, and are limited to 24 months of treatment, with the initial payment at banding of 20% and remaining payment prorated over the course of treatment.		
Orthodontic Services Services or supplies furnished by a Dentist to a Member and his or her Enrolled Dependent under age 19 in order to diagnose or correct misalignment of the teeth or the bite.	50%	50%
Appliance Therapy, Fixed or Removable Limited to 1 time per 60 consecutive months. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied.	OUT-OF-NETWORK COINSURANCE is shown as a percentage of the Plan Allowance after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Plan Allowance.
Cephalometric Film Limited to 1 per consecutive 12 months. Can only be billed for orthodontics.	100%	90%

SOLSTICE DENTAL

NOTICE OF PRIVACY PRACTICES

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

Effective: January 1, 2012

Medical Information Privacy Notice

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

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you a revised notice by direct mail or electronically as permitted by applicable law. In all cases, we will post the revised notice on our website. See the *Contacting Solstice* section in the *Introduction to Your Certificate* for the website address. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

How We Use or Disclose Information

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

A. To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and

B. To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

C. Where required by law.

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

A. **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.

B. **For Treatment***.* We may disclose health information to your doctors or hospitals to help them provide medical care to you.

C. **For Health Care Operations***.* We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.

D. **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.

E. **To Plan Sponsors***.* If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restriction on its use and disclosure of the information in accordance with federal law.

F. **For Reminders***.* We may use or disclose health information to send you about your benefits or care, such as appointment reminders with providers who provide medical care to you.

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

A. **As Required by Law.** We may disclose information when required to do so by law.

B. **To Persons Involved with your Care***.* We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests.

C. **For Public Health Activities** such as reporting or preventing disease outbreaks.

D. **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, that are authorized by law to receive such information, including a social service or protective service agency.

E. **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.

F. **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.

G. **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

H. **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

I. **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

J. **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers' compensation laws that govern job-related injuries or illness.

K. **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.

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

M. **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.

N. **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

O. **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

P. **For Data Breach Notification Purposes.** We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Q. **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

    1. HIV/AIDS;
    2. Mental health;
    3. Genetic tests;
    4. Alcohol and drug abuse;
    5. Sexually transmitted diseases and reproductive health information; and
    6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a Summary of Federal and State Laws on Use and Disclosure of Certain Types of Medical Information.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a **written authorization from you**. To be valid, an authorization to disclose such health information must be in written or electronic form; identify the subject of the health information; provide a general

description of the types of health information to be disclosed; provide a general description of the parties to whom the information will be disclosed; state the purpose of the disclosure and how the information will be used; contain the signature of the subject of the health information, or of the person who is legally empowered to grant authority; and contain the date signed. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. Each authorization is valid for 24 months. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. We will maintain a copy of your authorization in your record. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on the back of your ID card, or in the *Introduction to Your Certificate: Contacting Solstice* section of this *Certificate*.

What Are your Rights?

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

A. **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**

B. **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. We will accept verbal requests to receive confidential communications, but requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed in *Introduction to Your Certificate: Contacting Solstice.*

C. **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may in some cases receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed in *Introduction to Your Certificate: Contacting Solstice.* In certain limited circumstances, we may deny your request to inspect and copy your health information. We may charge a reasonable fee for any copies. If we deny your request, you have the right to have the denial reviewed. If we maintain an electronic health record containing your health information, when and if we are required by law, you will have the right to request that we send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.

D. **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed in *Introduction to Your Certificate: Contacting Solstice.* If we deny your request, you may have a statement of your disagreement added to your health information.

E. **You have the right to receive an accounting** of disclosures of your information made by us during the six (6) years prior to your request. This accounting will not include disclosures of information: (i) made before April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; (iv) to correctional institutions or law enforcement officials; and (v) other disclosures for which federal law does not require us to provide an accounting.

F. **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You

also may get a copy of this notice at our website**.** See *Introduction to Your Certificate: Contacting Solstice* for the website address*.*

Exercising your Rights

A. **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the toll-free member phone number listed on the back of your ID card. You may also find this number in the *Introduction to Your Certificate: Contacting Solstice* section of this *Certificate*.

B. **Submitting a Written Request.** Mail to us your written requests for modifying or cancelling a confidential communication, for copies of your records, or for amendments to your record, at the address listed in the *Introduction to Your Certificate: Contacting Solstice* section of this *Certificate*.

C. **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed in the *Introduction to Your Certificate: Contacting Solstice* section of this *Certificate*.

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

Financial Information Privacy Notice

We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and, is collected from the individual or is obtained in connection with providing health care coverage to the individual.

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

A. Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;

B. Information about your transactions with us, our affiliates or others, such as premium payment history; and

C. Information from consumer reports.

Disclosure of Information. We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

A. To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;

B. To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and

C. To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security. We restrict access to personal financial information about you to employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards in compliance with state and federal standards to guard your personal financial information. We conduct regular audits to help ensure appropriate and secure handling and processing of our enrollees' information.

Questions About this Notice. If you have any questions about this notice or want to exercise any of your rights, please call the toll-free member phone number listed on the back of your ID card. You may also find this number in the *Introduction to Your Certificate: Contacting Solstice* section of this *Certificate*.

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

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

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients.	CA, NE, RI, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of such health information.	NV
We are not allowed to use health information for certain purposes.	CA, NH
Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and/or (2) to specific recipients.	ID, NV
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AZ, IN, MI, OK
You may be able to restrict certain electronic disclosures of such health information.	NV
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	MT, NJ, WA
You may be able to restrict certain electronic disclosures of such health information.	NV
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited	CT, HI, KY, IL, IN, IA, LA, MD, MA, NH, NV, WA, WI

circumstances, and/or disclose only (2) to specific recipients.	
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, HI, IL, KY, NY, TN
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	GA, IA, MD, MA, MO, NV, NH, NM, RI, SC, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, OH, SC, SD, UT, VT
HIV/AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, HI, IL, IN, MI, MT, NY, NC, PA, PR, RI, TX, VT, WVI
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT
You may be able to restrict certain electronic disclosures of such health information.	NV
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, HI, IL, IN, KY, MA, MI, PR, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, NE, NJ, NM, RI, TN, TX, UT, WI
You may be able to limit or restrict certain electronic disclosures of such health information.	NV

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information About your Plan and Benefits

You are entitled to examine all documents governing the Plan, including: insurance contracts; collective bargaining agreements; and 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 *Employee Benefits Security Administration*. You are entitled to examine the above documents without charge to you. The above documents are available at your Plan Administrator's office and at other specified locations, such as worksites and union halls.

Upon written request to your Plan Administrator, you are entitled to copies of the above documents governing the operation of the plan and the updated *Summary Plan Description*. Your Plan Administrator may make a reasonable charge for the copies.

You are entitled to receive a summary of the plan's annual financial report. Your Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

You are entitled to 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. The Enrolling Group is responsible for providing you notice of your *COBRA* continuation rights. Review this *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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 your plan are called "fiduciaries" of the plan. Fiduciaries have a duty to act 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*.

Enforce your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know, within certain time schedules: why this was done; to get copies of documents relating to the decision without charge; and to appeal any denial. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from your Plan Administrator and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require your 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 your Plan 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. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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 will 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 fees. If you lose, the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your plan, you should contact your Plan Administrator. If you need help in obtaining documents from your Plan Administrator, you should contact the *Employee Benefits Security Administration.* If you have any questions about this statement or your rights under *ERISA,* you should contact the *Employee Benefits Security Administration*.

The nearest office of *Employee Benefits Security Administration*, *United States Department of Labor* is listed in your telephone directory. You can write the *Division of Technical Assistance and Inquiries*, *Employee Benefits Security Administration*, *U.S. Department of Labor* at 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You may also get certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.