

SERFF Tracking Number: WESA-126545262 State: Arkansas
Filing Company: Dentegra Insurance Company State Tracking Number: 45491
Company Tracking Number: I-PPO-C-AR-09
TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
Product Name: Dentegra PPO
Project Name/Number: Dentegra PPO/I-PPO-C-AR-09

Filing at a Glance

Company: Dentegra Insurance Company

Product Name: Dentegra PPO

TOI: H101 Individual Health - Dental

Sub-TOI: H101.000 Health - Dental

Filing Type: Form/Rate

SERFF Tr Num: WESA-126545262 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 45491

Co Tr Num: I-PPO-C-AR-09

State Status: Approved-Closed

Author: Darcy Lebau

Reviewer(s): Rosalind Minor

Date Submitted: 04/23/2010

Disposition Date: 07/09/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Dentegra PPO

Project Number: I-PPO-C-AR-09

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 07/09/2010

Deemer Date:

Submitted By: Darcy Lebau

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 04/13/2010

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 07/09/2010

Created By: Darcy Lebau

Corresponding Filing Tracking Number: I-PPO-
C-AR-09

Filing Description:

April 19, 2010 via SERFF

The Honorable Julie Benafield Bowman

Commissioner of Insurance

Arkansas Insurance Department

1200 W. 3rd Street

Little Rock, AR 72201

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Attention: Life & Health Division

Re: Dentegra Insurance Company
FEIN#: 75-1233841
NAIC#: 73474

Arkansas Dentegra PPO Policy – Form #I-PPO-C-AR-09
Dentegra PPO Individual/Family Dental Insurance Application – Form # EF-I-ST -09
Arkansas Dentegra PPO Outline of Coverage – Form # OOC-I-PPO-AR-2010

Honorable Commissioner Bowman:

I respectfully submit the form filing referenced above on behalf of Dentegra Insurance Company (“Dentegra”) for your review and approval prior to use in your state. Westmont Associates, Inc. has been requested to file these forms on behalf of Dentegra. Please see the enclosed authorization letter.

This is a new individual dental Preferred Provider Organization (“PPO”) product submission. The forms are new and are not intended to replace any other forms currently in use.

Arkansas Dentegra PPO Policy, Form #I-PPO-C-AR-09 provides dental PPO benefits on an individual basis. Optional provisions are chosen by the policyholder at the time of application. Certain wording and benefit amounts reflected in the subject forms is enclosed within brackets ([]) and may vary according to a specific plan design. The variable material shown in the policy reflects the benefit levels selected and insured specific information. The variable language or amounts on final printed forms will be no more restrictive than that which is reflected in the enclosed forms and within legal requirements. Please see the enclosed Statement of Variability for Dentegra’s explanation of how these forms may vary to accommodate different product offerings.

The Dentegra PPO Individual/Family Dental Insurance Application, Form # EF-I-ST -09, will be used for individual enrollment and will be signed by the policyholder.

The enclosed Dentegra PPO insurance product will be marketed by licensed agents, brokers, and third party administrators and online.

In accordance with Arkansas’s filing requirements, enclosed please find:

- Letter of Authorization
- Forms
- Readability Certification
- Statement of Variability

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- Actuarial Memorandum
- Rate Exhibits

I thank you in advance for the time spent on this filing and trust that you will find everything in order. Please do not hesitate to contact me directly at 856-216-0220, x 221 or at Darcy@Westmontlaw.com if you have any questions or require additional information.

Respectfully,

Darcy Lebau
Darcy Lebau

Company and Contact

Filing Contact Information

Darcy LeBau, darcy@westmontlaw.com
25 Chestnut Street, Suite 105 856-216-0220 [Phone]
Haddonfield, NJ 08033

Filing Company Information

(This filing was made by a third party - westmontassociatesinc)

Dentegra Insurance Company	CoCode: 73474	State of Domicile: Delaware
100 First Street	Group Code: 2479	Company Type: Life & Health
San Francisco, CA 94105	Group Name:	State ID Number:
(866) 714-7730 ext. [Phone]	FEIN Number: 75-1233841	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$200.00
Retaliatory?	Yes
Fee Explanation:	Dentegra's domiciliary state of Delaware charges \$50/form and \$50/rate. There are 3 forms in this filing, 3 x \$50 = \$150. \$150 + \$50/rate = \$200.
Per Company:	No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Dentegra Insurance Company	\$200.00	04/23/2010	35910225

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/09/2010	07/09/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	04/27/2010	04/27/2010	Darcy Lebau	07/09/2010	07/09/2010

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Disposition

Disposition Date: 07/09/2010

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Dentegra Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Statements of Variability	Approved-Closed	Yes
Supporting Document	Letter of Authorization	Approved-Closed	Yes
Supporting Document	Redline Policy	Approved-Closed	Yes
Form (revised)	Dentegra PPO Policy	Approved-Closed	Yes
Form	Dentegra PPO Policy	Replaced	Yes
Form	Individual/Family Dental Insurance Application	Approved-Closed	Yes
Form	Outline of Coverage & Disclosure	Approved-Closed	Yes
Rate	Actuarial Memorandum for Arkansas	Approved-Closed	No
Rate	Dentegra Manual Rating Exhibits PPO Individual	Approved-Closed	No

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 04/27/2010

Submitted Date 04/27/2010

Respond By Date

Dear Darcy LeBau,

This will acknowledge receipt of the captioned filing.

Objection 1

- Dentegra PPO Policy, I-PPO-C-AR-09 (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Objection 2

- Dentegra PPO Policy, I-PPO-C-AR-09 (Form)

Comment:

There needs to be a provision for the refund of unearned premium i the event of death of the insured. Refer to ACA 23-85-134.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Response Letter

Response Letter Status Submitted to State
 Response Letter Date 07/09/2010
 Submitted Date 07/09/2010

Dear Rosalind Minor,

Comments:

Good afternoon, Rosalind.

Please accept this Response Letter as Dentegra Insurance Company's reply to your Objection Letter.

Response 1

Comments: Please see revised Policy and redlined Policy form.

Related Objection 1

Applies To:

- Dentegra PPO Policy, I-PPO-C-AR-09 (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Redline Policy

Comment: Redlined Policy is attached.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Dentegra PPO Policy	I-PPO-C-AR-09		Policy/Contract/Fraternal Certificate	Initial		51.500	I-PPO-C-AR-09 4-28-10.pdf

SERFF Tracking Number: WESA-126545262 State: Arkansas
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 Product Name: Dentegra PPO
 Project Name/Number: Dentegra PPO/I-PPO-C-AR-09

Previous Version

Dentegra PPO Policy	I-PPO-C-AR-09	Policy/Contract/Fraternal Certificate	Initial	51.500	I-PPO-C-AR-09 4-15-10.pdf
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No Rate/Rule Schedule items changed.

Response 2

Comments: Please see revised Policy and redlined Policy form.

Related Objection 1

Applies To:

- Dentegra PPO Policy, I-PPO-C-AR-09 (Form)

Comment:

There needs to be a provision for the refund of unearned premium i the event of death of the insured. Refer to ACA 23-85-134.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Redline Policy

Comment: Redlined Policy is attached.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Dentegra PPO Policy	I-PPO-C-AR-09		Policy/Contract/Fraternal Certificate	Initial		51.500	I-PPO-C-AR-09 4-28-10.pdf

Previous Version

Dentegra PPO Policy	I-PPO-C-AR-09		Policy/Contract/Fraternal Certificate	Initial		51.500	I-PPO-C-AR-09 4-15-10.pdf
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Product Name: Dentegra PPO

Project Name/Number: Dentegra PPO/I-PPO-C-AR-09

No Rate/Rule Schedule items changed.

Thank you for your time and attention to this filing.

Respectfully,

Darcy Lebau

Sincerely,

Darcy Lebau

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Form Schedule

Lead Form Number: I-PPO-C-AR-09

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/09/2010	I-PPO-C-AR-09	Policy/Cont ract/Fratern al Certificate	Dentegra PPO Policy	Initial		51.500	I-PPO-C-AR-09 4-28-10.pdf
Approved-Closed 07/09/2010	EF-I-ST-09	Application/ Enrollment Form	Individual/Family Dental Insurance Application	Initial		56.900	EF-I-ST-09 4-12-10.pdf
Approved-Closed 07/09/2010	OOC-I-PPO-AR-2010	Outline of Coverage	Outline of Coverage & Disclosure	Initial		47.100	OOC-I-PPO-AR-2010 4-15-10.pdf



Dentegra Dental PPO for Individuals and Families



www.dentegra.com

Policy

Your dental plan is underwritten by Dentegra Insurance Company (“Dentegra”). Dentegra will pay Benefits for covered dental services as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first installment of premium. It takes effect on the Effective Date shown on the Benefits Summary attached to this Policy. This Policy will remain in force unless otherwise terminated in accordance with its terms, until the first renewal date and for such further periods for which it is renewed. All periods will begin and end at 12:01 A.M., Standard Time, where you live.

READ YOUR POLICY AND BENEFITS SUMMARY CAREFULLY

**This Policy is a legal agreement between the Primary Enrollee and
Dentegra Insurance Company**

10-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

Please read this Policy. If you are not satisfied for any reason, you may return this Policy within 10 days after you received it. Mail or deliver it to Dentegra or the agent through whom it was purchased. Any premium paid will be refunded. This Policy will then be void from its start.

This Policy is signed for Dentegra Insurance Company, as of its Effective Date by:



Anthony S. Barth, Vice Chairman

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INTRODUCTION

We are pleased to welcome you to this individual Dentegra PPO dental plan. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the dentist, but to see him/her on a regular basis.

Using This Policy

This Policy discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the dental plan works and how to obtain dental care. Please read this Policy completely and carefully. Keep in mind that “you” and “your” mean the Enrollees who are covered under this plan. “We, “us” and “our” always refer to Dentegra.

Contact Us

If you have any questions about your coverage that are not answered here, please visit our web site at www.dentegra.com or call our Customer Service Center. A Customer Service representative can answer questions you may have about obtaining dental care, help you locate a Dentegra Provider, explain benefits, check the status of a claim, and assist you in filing a claim.

You can access our automated information line at 877-280-4204 during regular business hours to obtain information about Enrollee benefits, claim status or to speak to a Customer Service representative for assistance. If you prefer to write to us with your question(s) please mail your inquiry to the following address:

Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Identification Number

Please provide the Primary Enrollee’s ID number to your Provider whenever you or one of your enrolled family members receives dental services. The Enrollee ID number should be included on all claims submitted for payment. Identification cards are not required, but if you wish to have one you may obtain one by visiting our web site at www.dentegra.com.

DEFINITIONS

The following are definitions of words that have special or technical meanings under this Policy.

Accepted Fee: the amount the attending Provider agrees to accept as payment in full for services rendered.

Benefits (In-Network or Out-of-Network): the amounts that Dentegra will pay for dental services under this Policy. In-Network Benefits are those covered by this Policy and performed by a Dentegra Provider. Out-of-Network Benefits are those covered by this Policy but performed by a Non-Dentegra Provider.

Benefit Waiting Period: the period of time of continuous enrollment that an Enrollee must complete before certain dental procedures become covered benefits.

Calendar Year: the period of time beginning on January 1st and ending on December 31st.

Claim Form: the standard form used to file a claim or request a Pre-Treatment Estimate.

Deductible: a dollar amount that an Enrollee and/or the Enrollee's family (for family coverage) must pay for certain covered services before Dentegra begins paying benefits.

Dentegra PPO Provider (Dentegra Provider): a Provider who contracts with Dentegra and agrees to accept the Dentegra Contracted Fee as payment in full for services provided under a PPO plan. A Dentegra Provider also agrees to comply with Dentegra's administrative guidelines.

Dentegra PPO Provider's Contracted Fee (Dentegra Provider Contracted Fee): the fee for each Single Procedure that a Dentegra Provider has contractually agreed to accept as payment in full for treating Enrollees.

Dependent Enrollee: an Eligible Dependent enrolled to receive Benefits.

Effective Date: The date the plan starts. This date is given in your Benefits Summary.

Eligible Dependent: a dependent of the Primary Enrollee or domestic partner eligible for Benefits.

Enrollee: an individual who made application for this dental Policy ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits; may also be referred to as "Patient".

Maximum Contract Allowance: the reimbursement under the Enrollee’s benefit plan against which Dentegra calculates its payment and the Enrollee’s financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- [by a Dentegra Provider is the lesser of the Submitted Fee or the Dentegra Provider’s Contracted Fee; or
- by a Non-Dentegra Provider is the lesser of the Submitted Fee or the Dentegra Provider’s Contracted Fee for a Dentegra Provider in the same geographic [area](#)^[c1].]

- [by a Dentegra Provider is the lesser of the Submitted Fee on the claim or the Dentegra Provider’s Contracted Fee; or
- by a Non-Dentegra Provider is the lesser of the Submitted Fee on the claim or the Program [Allowance](#)^[c2].]

Non-Dentegra Provider: a Provider who is not a Dentegra Provider, is not contractually bound to abide by Dentegra’s administrative guidelines and has not agreed to accept the Dentegra Contracted Fees.

Patient Pays: Enrollee’s financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as “Dentegra Pays” on the claims statement when a claim is processed.

Policy: this contract of insurance issued and delivered to the Enrollee. It includes the application, any attached amendments, and any appendices.

Policy Benefit Level: the percentage of Maximum Contract Allowance that Dentegra will pay after the Deductible has been satisfied.

Policy Term: the period during which the Policy is in effect.

Policy Year: the 12 months starting on the Effective Date and each subsequent 12-month period thereafter. [Deductibles and maximums will be determined using this 12-month period rather than on a Calendar Year [basis](#)^[c3].]

Premium: the amount payable by the Enrollee as provided in the Benefits Summary.

Pre-Treatment Estimate: an estimation of the allowable Benefits under this Policy for the services proposed, assuming the person is an eligible Enrollee.

Primary Enrollee: the individual insured in this plan to receive Benefits.

Procedure Code: the Current Dental Terminology (CDT)[®] number assigned to a Single Procedure by the American Dental Association.

Program Allowance: the amount determined by a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area.

Provider: a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

Single Procedure: a dental procedure that is assigned a separate CDT© number.

Submitted Fee: the amount that the Provider bills and enters on a claim for a specific procedure.

ELIGIBILITY AND ENROLLMENT

Eligibility Requirement

Primary Enrollees electing to enroll their eligible family members must enroll them at the time the Primary Enrollee enrolls or within 90 days of the Primary Enrollees initial enrollment or within 31 days of a Qualifying Status Change.

Eligible family members include:

- Your spouse or domestic partner.
- Your unmarried dependent children from birth to their 19th birthday or 25th birthday, if a full-time student in an accredited school. Proof of full-time student status must be given to us within 60 days when requested. “Children” includes natural children, step-children, adopted children, children of your domestic partner, foster children and children for which you have been appointed legal guardian. The child must be dependent on you for support. Newborn infants are eligible from the moment of birth. Adopted children are eligible from the date a petition is filed if you apply for coverage within 60 days after the filing of the petition or from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the minor.
- Your unmarried children 19 years or older may continue to be eligible as a dependent if the child is incapable of self-sustaining employment due to mental incapacity or physical handicap that began before age 19 and the child is chiefly dependent on you for support and maintenance. Proof will not be required more than once a year after the child is 21.

Dependents serving active military duty are not eligible, as they are typically covered under health and dental insurance provided by the military while they are on active duty.

Qualifying Status Change is a change in:

- Legal marital status (marriage, divorce, legal separation, annulment or death); or
- Number of dependents (a child’s birth, adoption of a child, placement of a child for adoption; addition of a step or foster child or death of a child); or
- A loss of coverage under a provision dental benefits plan for reasons other than exceeding the annual or lifetime maximum benefits and provided that coverage existed for 90 continuous days without a break in coverage of more than 63 days;
or

-
- A dependent child ceases to satisfy eligibility requirements (limiting age or marital status); or
 - A court order requiring dependent coverage.

The additional Premium must be paid to us within 31 days after the date of the Qualifying Status Change in order to have the coverage continued beyond the 31 day period.

Enrollment Grace Period

There is a period of 10 days from your coverage Effective Date during which you may rescind this Policy and receive a full refund, provided you and all enrolled family members have not used any Benefits under this Policy.

[Minimum Enrollment Period

You and your covered family members selecting dental coverage must enroll for a minimum of [12] months. If coverage is voluntarily discontinued, you and your covered family members may not re-apply during the [12]-month period immediately following the voluntary termination^{[c4].}

RENEWABLE - PREMIUM MAY CHANGE CONDITIONALLY:

The Primary Enrollee may keep this Policy in force by timely payment of the premiums. However, Dentegra may refuse renewal due to:

- 1) Non-payment of premiums, subject to the “Grace Period on Late Payment” provision; or
- 2) Fraud or material misrepresentation made by or with the knowledge of the Primary Enrollee or an Eligible Dependent applying for this coverage or filing a claim for Benefits; or
- 3) The Primary Enrollee fails to comply with material provisions of this Policy; or
- 4) The company ceasing to renew all Policies issued on this form to residents of the state where you live.

At least 30 days notice of any non-renewal action permitted by this clause will be mailed to the Primary Enrollee at your last address as shown in Dentegra’s records. If Dentegra fails to provide 30 days notice of our intent to terminate coverage, your coverage will remain in effect until 30 days after notice is given or until the effective date of replacement coverage, whichever occurs first. However, no Benefits will be paid for expenses incurred during any period of time for which premium has not been paid.

Dentegra will provide 30 days advance written notice of any change in premium at renewal.

Termination of Coverage

You have the right to terminate your coverage under this Policy by sending us written notice of your intent to terminate this Policy. Termination of this Policy and coverage for you and all Enrollees under this Policy will be effective on the last day of the month that we receive your written request of termination.

A full refund of premium is available if a written request for a refund is made within the first 10 days of the Effective Date. After that, all requests for a premium refund will be prorated based upon the number of months remaining in the Policy Term, subject to the following exceptions:

- 1) A refund is not available if you or your Dependent Enrollee have received Benefits under this Policy;
- 2) There must be at least one month remaining in the Policy Term. Since coverage is based on a full calendar month, there are no partial month refunds.
- 3) Your Dependent Enrollee may disenroll from coverage under this Policy at any time. Termination of coverage for the disenrolled dependent shall occur on the last day of the month we receive written notice of the Enrollee's disenrollment. Coverage for your Dependent Enrollee will automatically terminate on the last day of the month in which the Enrollee no longer meets eligibility requirements.

We have the right to terminate this Policy and your coverage if you fail to pay your Premium or if your Premium payment is not received by us by the 31st day following the date it is due. Please see the section titled "Grace Period on Late Payments" for more information.

We also have the right to terminate your coverage:

- Upon 15 days written notice if you:
 - Are guilty of misconduct detrimental to safe operations and the delivery of services while in a Dentegra Provider's facility; or
 - Knowingly commit or permit another person to commit fraud or deception in obtaining Benefits.
- Upon 30 days written notice if you fail to pay coinsurance; provided however, that you may be reinstated during the Policy Term upon payment of all delinquent charges.

If your coverage is terminated, we will send a written notice to you informing you of the reason(s) why coverage is terminated and the date that your coverage will end. However, coverage will continue for 31 days to complete any Single Procedure begun but not completed before the Effective Date of termination.

In the event of termination or death of the insured, unearned premiums shall be paid in lump sum on a date no later than thirty (30) days after the proof of the insured's death has been furnished to us.

Reinstatement

If you do not pay your premium within the time granted for payment, your Policy will be terminated. If your Policy is terminated you [may re-enroll in the program and any waiting period, deductibles and maximum applicable to your program will start again.] [must wait [12] months before re-enrolling in the program and any waiting periods, deductible and maximums applicable to your program will start again^[LK5].] However, your Policy may be reinstated with no break in coverage provided the full premium due is received by us within 60 days of the date of the past due premium. The reinstated Policy will have the same rights as before your Policy lapsed, unless a change is made to your Policy in connection with the reinstatement. These changes, if any, will be sent to you for you to attach to your Policy.

OVERVIEW OF DENTAL BENEFITS

This section provides information that will give you a better understanding of how this dental plan works and how to make it work best for you.

[Benefit Waiting Period

Some of the services in your dental plan are subject to a waiting period. Please refer to your Benefits Summary (Appendix A). No exceptions or credits are given for prior coverage. Enrollees who terminate from the dental plan and later re-apply will be required to satisfy another [12]-month waiting period during the new enrollment with no credit for prior enrollment^[c6].

Benefits, Limitations and Exclusions

We will pay the Benefits for the types of dental services as described below. We will pay Benefits only for covered services. The services provided through this Policy are described in the Benefits Summary. This Policy covers several categories of benefits when a Provider furnishes the services and when they are necessary and within the standards of generally accepted dental practice. Claims shall be processed in accordance with our standard processing policies. We may use dentists (dental

consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Policy. Even if the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

Enrollee Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services, as shown in the Benefits Summary, subject to certain limitations, and you are responsible for paying the balance. What you pay is called the enrollee coinsurance (“Enrollee Coinsurance”) and is part of your out-of-pocket cost. You pay this even after a Deductible has been met.

The amount of your Enrollee Coinsurance will depend on the type of service and the Provider furnishing the service (see section titled “Selecting Your Provider”). Providers are required to collect Enrollee Coinsurance for covered services. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to you, we will be obligated to provide as Benefits only the applicable percentages of the Provider’s fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

It is to your advantage to select Dentegra Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to the sections titled “Selecting Your Provider” and “How Claims Are Paid” for more information.

Deductible

Your dental plan features a Deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The Deductible amounts are listed in the Benefits Summary. Deductibles apply to all benefits unless otherwise noted. Only the Provider’s fees you pay for covered Benefits will count toward the Deductible.

Maximum Amount

Your dental program has a maximum dollar amount we will pay toward the cost of dental care (“Maximum Amount”). You are responsible for paying costs above this amount. The Maximum Amount payable is shown in the Benefits Summary. Maximums may apply on a yearly basis, a per services basis, or a lifetime basis.

Benefits

To help you understand the types of procedures that are included in each category, the following is a description of each of the categories of services that are covered under this Policy.

We will pay the Policy Benefit Level shown in the Benefits Summary for the following services:

Diagnostic and Preventive Benefits:

- Diagnostic: procedures to assist the Provider in choosing required dental treatment.
- Preventive: cleaning [(periodontal cleaning in the presence of inflamed gums is considered to be a Basic Benefit for payment purposes)], topical application of fluoride solutions, and space maintainers.
- [Sealants: topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay^[c7].]

[Basic Benefits:

- [Oral Surgery: extractions and other surgical procedures (including pre- and post-operative care^[c8]).
- General Anesthesia or IV Sedation: when administered by a Provider for oral surgery or selected endodontic and periodontal surgical procedures.
- Anesthesia and hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a hospital or ambulatory surgical facility if the Provider certifies that, because of the Enrollee's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the patient is:
 - 1) a child under seven (7) years of age who is determined by two (2) licensed dentists to require, without delay, necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; or
 - 2) a person with a diagnosed serious mental or physical condition; or
 - 3) a person with a significant behavioral problem as determined by your licensed Provider.
- [Endodontics: treatment of diseases and injuries of the tooth pulp^[c9].]
- [Periodontics: treatment of gums and bones supporting teeth^[c10].]

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- [Palliative: treatment to relieve [pain](#)^[LK11].]
 - [Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing [decay](#)^[c12].]
 - [Restorative: amalgam, synthetic porcelain, plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of [decay](#)^[c13]).]
 - [Denture Repairs: repair to partial or complete dentures including rebase procedures and [relining](#)^[c14].]

[Major Benefits:

- [Oral Surgery: extractions and other surgical procedures (including pre- and post-operative [care](#)^[c15]).]
- [Endodontics: treatment of diseases and injuries of the tooth [pulp](#)^[c16].]
- [Orthodontic: procedures performed by a Provider using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their [function](#)^[LK17]]
- [Periodontics: treatment of gums and bones supporting [teeth](#)^[c18].]
- [Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain or plastic [restorations](#)^[c19].]
- [Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; [implant surgical placement and removal; and for implant supported prosthetics, including implant repair and [recementation](#)^[c20].]
- [Implants: procedures performed by a Provider for endodontic endosseous, endosteal, eposteal and transosteal implants; implant connecting bars and implant repairs. Implants are defined as prosthetic applicances placed into or on the bone of the maxilla or mandible (upper or lower jaw) to retain or support dental [prosthesis](#)^[LK21]]
- [Dental Accident: An injury to the mouth or structures within the oral cavity which is caused by an external traumatic force. It does not include damage to the teeth which is the result of biting into food or other substances. Procedures shall include but are not limited to reimplantation, splinting and [stayplate](#)^[LK22].]

Note on additional Benefits during pregnancy: When an Enrollee is pregnant, we will pay for additional services during the pregnancy. The additional services each [12 month^{c23} period] [Policy Year] while the Enrollee is covered under this Policy include: one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

Limitations and Exclusions

Dental plans are designed to help with part of your dental expenses and may not always cover every dental need. The typical program includes Limitations and Exclusions, meaning the program does not cover every aspect of dental care. This can relate to the type of procedures or the number of visits. Please read the following sections to help you understand the Limitations and Exclusions of this dental plan.

Limitations

Benefits to Enrollees are limited as follows:

Limitations on Diagnostic and Preventive Benefits:

- We will pay for routine oral examinations (including any office visits for observation and specialist consultations, or combination thereof), cleanings (including periodontal cleanings or any combination thereof) and topical application of fluoride solutions no more than [twice^{LK24}] in any 12 month period. Note that periodontal cleanings are covered as a [Basic Benefit] and^{c25} routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional benefits during pregnancy.
- Specialist consultations are only a Benefit when an opinion or advice is requested by a general dentist and the treatment is not performed by the specialist.
- X-ray limitations:
 - a) Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
 - b) When a panoramic film is submitted with supplemental film(s), Dentegra will limit the total reimbursable amount to the Accepted Fee for a complete intraoral series.

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- c) If a panoramic film is taken in conjunction with an intraoral complete series, Dentegra considers the panoramic film to be included in the complete series.
 - d) A complete intraoral series and panoramic films by the same Provider/Provider office are limited to once each every [five (5)] years^[c26].
 - e) Bitewing x-rays are limited to [two (2) times in any 12 month period] when provided to Enrollees under 18 and [one (1) time each 12 months] for Enrollees age 18 and over. Bitewings are not a Benefit within six (6) months of an intraoral complete series unless warranted by special circumstances such as active periodontal disease or rampant caries^[c27].
 - [Topical application of fluoride solutions is limited to Enrollees to age 19^[c28].]
 - Space maintainers are limited to the initial appliance and are a benefit for an Enrollee under age [14^[c29]]. For Enrollees ages 14 and 15, an allowance for a space maintainer will be considered until a fixed bridges or removable partial dentures can be placed.
 - Cephalometric x-rays, oral/facial photographic images (once per case) and diagnostic casts (once per case) are benefits only in conjunction with orthodontic services and only when orthodontic services are a covered Benefit.
 - [Sealants are limited as follows^[c30]:
 - a) to permanent first molars through age [eight (8)] and to permanent second molars through age [15] if they are without caries (decay) or restorations on the occlusal surface.
 - b) do not include repair or replacement of a sealant on any tooth within [two (2)] years of its application^[c31].]

Limitations on Basic Benefits:

- [Sealants are limited as follows^[c32]:
 - a) to permanent first molars through age [eight (8)] and to permanent second molars through age [15] if they are without caries (decay) or restorations on the occlusal surface.
 - b) do not include repair or replacement of a sealant on any tooth within [two (2)] years of its application^[c33].]
- We will not pay to replace an amalgam, synthetic porcelain or plastic restorations (fillings) or prefabricated resin and stainless steel crowns within [24 months^[c34]] of treatment if the service is provided by the same Provider.

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- We limit payment for prefabricated resin and stainless steel crowns under this section to services on baby (deciduous) teeth. However, after a consultant's review, we may allow stainless steel crowns on permanent teeth as a [Major Benefit^[c35].]
 - [Retreatment of root canal therapy within 24 months of the initial procedure is not a Benefit when performed by the same Provider^[c36].]
 - [Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing.] See note on additional Benefits during pregnancy^[c37].
 - Extractions and oral surgery procedures performed for Orthodontic treatment are not a Benefit except as provided under Orthodontic Benefits, if applicable.

Limitations on Major Benefits:

- Crowns, inlays/onlays and cast restorations are covered no more often than once in any [five (5) year period] except when we determine the existing crown, or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues^[c38].
- Prosthodontic appliances and/or implants that were provided under any Dentegra program will be replaced only after [five (5) years^[c39]] have passed, except when we determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Dentegra program will be made if we determine it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Dentegra's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Dentegra or any other dental care plan.
- When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.
- Recementation of crowns, inlays/onlays or bridges is not a Benefit when performed by the same Provider within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation.
- [The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is

made necessary by natural, permanent teeth extraction occurring during a time you were eligible under a Dentegra [program][c40].]

- We limit payment for dentures to a standard partial or denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care and rebase (including relining and any adjustments) for the first six (6) months after placement. Additional Denture benefit limitations are:
 - a) Denture rebase is limited to one (1) per arch in a 24 month period.
 - b) Denture relines and tissue conditioning are limited to two (2) per arch in a 12 month period. Tissue conditioning provided on the same day a denture is delivered or a reline or rebase has been performed is not a Benefit.
- The Orthodontic Benefit maximum amount payable for each Enrollee during the Enrollee's [lifetime][Policy Year][LK41] is shown in the Benefits Summary. Additional Orthodontic benefit limitations are:
 - a) Orthodontic Benefits will be provided in two (2) payments after the person becomes covered, (one initial payment and the second in twelve (12) months), except for treatment plans of less than \$500 which will be paid in one (1) [payment][c42].
 - b) Orthodontic Benefits are not paid to repair or replace any orthodontic appliance received under this program.
 - c) Non-Orthodontic procedures performed for the purpose of Orthodontic treatment are subject to the Orthodontic Benefit and maximum if covered as Benefits under Dentegra's standard processing policies.
 - d) Orthodontic Benefits are limited to dependent child Enrollees under the age of 19[c43].]
- Implant Benefits are subject to all the Limitations, Exclusions and other terms and conditions in this Policy. Additional implant benefit limitations are:
 - a) Diagnostic and treatment facilitating aids are considered a part of, and included in, the fees for the definitive treatment.
 - b) Bone graphs provided for implants on the same day as service.
- Dental Accident Benefits are subject to all the Limitations, Exclusions and other terms and conditions in this Policy. Additional Dental Accident benefit limitations are:
 - a) The dental accident must occur while you are covered under this Policy.

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- b) Services and procedures must be provided within 180 days following the dental accident and while you are covered under this Policy.

Limitations on All Benefits - Optional Services:

Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called “Optional Services”. Optional Services also include the use of specialized techniques instead of standard procedures. For example:

- A Crown where a filling would restore the tooth; or
- a precision denture/partial where a standard denture/partial could be used; or
- an Inlay/Onlay instead of an amalgam restoration; or
- porcelain, resin or similar materials for Crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a full metal crown) [; or/.]
- [a composite restoration instead of an amalgam restoration on posterior teeth^[c44].]

If you receive Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. You will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

Exclusions

This Policy covers a wide variety of dental care expenses, but there are some services for which we do not provide benefits. It is important for you to know what these services are before you visit your Provider.

We do not pay benefits for:

- Treatment of injuries or illness covered by workers’ compensation or employers’ liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- Cosmetic surgery or procedures for purely cosmetic reasons.
- Maxillofacial prosthetics.
- Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those

services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.

- Treatment to restore tooth structure lost from wear, erosion, or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize teeth. Examples include but are not limited to: equilibration, periodontal splinting, occlusal adjustments or occlusal guards.
- Single surface restorations placed on the same surface as a sealant and within 12 months of the initial sealant application or multiple surface restorations placed on the same surface as a sealant and within six (6) months of the initial sealant application.
- Any Single Procedure started prior to the date the Enrollee became covered under this plan.
- Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental procedures.
- Charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed Provider in connection with oral surgery or selected endodontic and periodontal surgical procedures, except as allowed under Basic Benefits.
- Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- Porcelain and porcelain fused to metal crowns for Enrollees under age 12.
- Fixed bridges and removable partials for Enrollees under age 16.
- Interim implants.
- Resin-based inlays and onlays.
- Overdentures.
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- Treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments.
- Dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary

materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

- Services or supplies covered by any other health plan.
- Treatment rendered by a person who ordinarily resides in your household or who is related to you (or to your spouse) by blood, marriage or legal adoption.
- Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- [The initial placement of any prosthodontic appliance or implants unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under this Policy or was covered under any dental care program with Dentegra. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth[D45].]
- Services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Major Benefit section, if applicable.
- Procedures performed for the purpose of orthodontic treatment are not a Benefit except as provided under Major Benefits, if applicable.
- Services for any disturbance of the temporomandibular (jaw) joints or associated musculature, nerves and other tissues (TMJ).
- [Services or supplies for oral surgery, general anesthesia, palliative treatment, or sealants[D46].]
- [Services or supplies for endodontic treatment[D47] (procedures for removal of the nerve of the tooth and the treatment of the pulp cavity portion of the root of the tooth).]
- [Services or supplies for periodontic treatment (procedures for the treatment of the gums and the bones supporting teeth[D48]).]
- [Services or supplies for restorative treatment (amalgam, synthetic porcelain, plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).][D49]
- [Services or supplies for denture repairs (repair to partial or complete dentures including rebase procedures and relining.)][D50]
- [Services or supplies for crowns, cast restorations, inlays/onlays for treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain, plastic restorations.][D51]

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- [Services or supplies for prosthodontic benefits (procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges.)][D52]
 - [Services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures][LK53].]

Pre-Treatment Estimates

Pre-treatment estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. We will estimate the amount of Benefits payable under this Policy for the listed services. By asking your Provider for a Pre-Treatment Estimate from us before you agree to receive any prescribed treatment, you will have an estimate up front of what we will pay and the difference you will need to pay. The Benefits will be processed according to the terms of this Policy when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days, or until an earlier occurrence of any one of the following events:

- 1) the date this Policy terminates;
- 2) the date the Dependent Enrollee's coverage ends; or
- 3) the date the Provider's agreement with Dentegra ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if you are covered and meet all the requirements of the plan at the time the treatment you have planned is completed and may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

SELECTING YOUR PROVIDER

Free Choice of Provider

We recognize that many factors affect the choice of Provider and therefore support your right to freedom of choice regarding your Provider. This assures that you have full access to the dental treatment you need from the dental office of your choice. You may see any Provider for your covered treatment, whether the Provider is a Dentegra Provider or a Non-Dentegra Provider. In addition, you and your family members can see different Providers.

Remember, you enjoy the greatest benefits—including out-of-pocket savings—when you choose a Dentegra Provider. To take full advantage of your benefits, we highly recommend you verify a dentist's participation status within a Dentegra network with your dental office before each appointment. Review the section titled "How Claims

Are Paid” for an explanation of Dentegra payment procedures to understand the method of payments applicable to your Provider selection and how that may impact your out-of-pocket costs.

Locating a Dentegra Provider

You may access information through our web site at www.dentegra.com. You may also call our Customer Service Center and one of our representatives will assist you. We can provide you with information regarding a Provider’s network, specialty and office location.

HOW CLAIMS ARE PAID

Payment for Services — Dentegra Provider

Payment for covered services performed for you by a Dentegra Provider is calculated based on the Maximum Contract Allowance, which is the lesser of the submitted fee on the claim or the Dentegra Provider’s Contracted Fee. Dentegra Providers have agreed to accept the Dentegra Provider’s Contracted Fee as the full charge for covered services.

The portion of the Maximum Contract Allowance payable by us is limited to the applicable Policy Benefit Level shown in the Benefits Summary. Dentegra’s payment is sent directly to the Dentegra Provider who submitted the claim. We advise you of any charges not payable by us for which you are responsible. These charges are generally your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

Payment for Services — Non-Dentegra Provider

Payment for services performed for you by a Non-Dentegra Provider is also calculated based on the Maximum Contract Allowance. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Policy Benefit Level shown in the Benefits Summary.

However, when dental services are received from a Non-Dentegra Provider, Dentegra’s Payment is sent directly to the Primary Enrollee. You are responsible for payment of the Non-Dentegra Provider’s Submitted Fee. Non-Dentegra Providers will bill you for their normal charges, which may be higher than the Maximum Contract Allowance for the service. You may be required to pay the Provider yourself and then submit a claim to us for reimbursement. Since our payment for services you receive may be less than the Non-Dentegra Provider’s actual charges, your out-of-pocket cost may be significantly higher.

How to Submit a Claim

Claims for Benefits must be filed on a standard Claim Form, which most dental offices have available. Dentegra Providers will fill out and submit your claims paperwork for you. Some Non-Dentegra Providers may also provide this service upon your request. If you receive services from a Non-Dentegra Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled “Claim Form” for more information.

Your dental office should be able to assist you in filling out the claim form. Fill out the claim form completely and send it to:

Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Payment Guidelines

We do not pay Dentegra Providers any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If you or your Provider files a claim for services more than 12 months after the date you received the services, payment may be denied. If the services were received from a Non-Dentegra Provider, you are still responsible for the full cost. If the payment is denied because your Dentegra Provider failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your Dentegra Provider that you were covered under a Dentegra Policy at the time you received the service, you may be responsible for the cost of that service.

We explain to all Dentegra Providers how we determine or deny payment for services. We describe in detail the dental procedures covered as benefits, the conditions under which coverage is provided and the plan’s limitations and exclusions. If any services are not covered, or if limitations or exclusions apply to services you have received, you may be responsible for the full payment.

If you have any questions about any dental charges, processing policies and/or how your claim is paid, please contact us.

PREMIUM PAYMENT RESPONSIBILITIES

The Primary Enrollee is responsible for making premium payments, paying Deductibles and Enrollee Coinsurance and ensuring your Provider is aware of any other dental coverage you carry. These are explained in detail in the following subsections.

[Rate Guarantee

For plans with waiting periods, your initial premium rate is guaranteed for the first two years of continuous coverage under your Policy, based upon the new enrollee rates in force at the time you apply for coverage. After the first two years, premium rates may be adjusted annually. If you move, or change your enrollment options, your premium rate may also [change](#)^[c54].

Premium Billing

When you completed your application, you selected your dental benefits and the method for paying your ongoing premiums, either by check or through Electronic Funds Transfer (EFT). The following is a description of how each of these methods works.

Pay by Check

If you selected to pay by check, you also selected the option of paying your premiums quarterly, semi-annually or annually.

If you elected to pay your premiums quarterly, semi-annually, or annually, you will receive an invoice once every billing period.

Your payment must be received by the 20th of the month in which it is due to ensure coverage for the following billing period. All payments are to be mailed to the following address:

Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Pay by Electronic Funds Transfer (EFT)

If you chose to pay your premium on a monthly basis through monthly EFT, Dentegra will transfer the premium payment from your bank account at the end of each month for the following month's coverage.

If funds aren't available, your account will be considered delinquent.

If the account continues to be delinquent for more than 31 days, your Policy will be terminated.

Changing Payment Options

Payment options may be changed at any time; however, the effective date of the change varies dependent on your payment option. Changes to EFT, quarterly and semi-annual

payment options are effective on the anniversary or semi-anniversary of your Policy Effective Date. Changes to the annual payment option are effective on the anniversary of your Policy Effective Date. To change your payment option you can call our Customer Service Center toll-free at 877-280-4204 during regular business hours or write to the Customer Service Center at:

Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023

Grace Period on Late Payments

If your premium payment is not received by the first of the month a grace period of 31 days will be granted. During the grace period the Policy shall continue in force.

If the account continues to be delinquent for more than 31 days, your Policy will be terminated.

COMPLAINTS AND APPEALS

Our commitment to you is to ensure quality throughout the entire dental benefit process: from the courtesy extended to you by our Customer Service representatives to the dental services provided by Dentegra Providers. If you have questions about any services received, we recommend that you first discuss the matter with your Provider. However, if you continue to have concerns, please call our Customer Service Center. You can also e-mail questions by accessing the “Contact Us” section of our web site at www.dentegra.com.

Complaints regarding eligibility, the denial of dental services or claims, the policies, procedures, or operations of Dentegra, or the quality of dental services performed by the Provider may be directed in writing to us or by calling us toll-free at 877-280-4204.

When you write, please include the name of the Enrollee, the Primary Enrollee’s name and ID number, and your telephone number on all correspondence. You should also include a copy of the claim form, claim statement, or other relevant information. Your claim statement will have an explanation of the claim review and any complaint process and time limits applicable to such process.

We will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. You and your Provider have at least 180 days after receiving a notice of denial to request a review by writing to Dentegra giving reasons why you believe the denial was wrong. You may also ask

Dentegra to examine any additional information you include that may support your complaint.

Send your complaint to us at the address shown below:

Dentegra Insurance Company

P.O. Box 1809

Alpharetta, GA 30023

We will send you a written acknowledgment within 5 days upon receipt of your complaint. We will make a full and fair review within 30 days after we receive the complaint. We may ask for more documents if needed. We will send you a decision within 30 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of this Policy, we shall consult with a dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual.

Appeals

If you believe you need further review of your claim and/or your complaint, you may contact your state insurance regulatory agency.

PROVISIONS REQUIRED BY LAW

Entire Contract; Changes

This Policy, including the endorsements and the attached papers, constitutes the entire contract of insurance. No change to this Policy shall be valid until approved by our executive officer and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

Incontestability

After 3 years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by you in the application for this Policy will be used to void the Policy or to deny a claim for loss incurred or disability commencing after the expiration of such 3-year period.

No claim for loss incurred or disability commencing after 3 years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical

condition not excluded from coverage by name or specific description effective on the date of loss has existed prior to the effective date of this Policy.

Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, you as may be required to administer the claim, or have you be examined by a dental consultant retained by us, at our own expense, in or near your community or residence. We will in every case hold such information and records confidential.

Written Notice of Claim/Proof of Loss

We must be given written proof of loss within 12 months after the date of the loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give written proof in the time required, provided that the proof is filed as soon as reasonably possible. A notice of claim submitted by you, on your behalf, or on behalf of your beneficiary to us or to our authorized agent, with information sufficient to identify you will be considered notice of claim.

All written proof of loss must be given to us within 12 months of the termination of this Policy.

Send your Notice of Claim/Proof of Loss to us at the address shown below:

Dentegra Insurance Company

P.O. Box 1809

Alpharetta, GA 30023

Claim Form

We will, within 15 days after receiving a notice of a claim, provide you or your Provider with a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If we do not send you or your provider a claim form within 15 days after you or your Provider gave us notice regarding a claim, the requirements for proof of loss outlined in the section "Written Notice of Claim/Proof of Loss" above will be deemed to have been complied with as long as you give us written proof that explains the type and the

extent of the loss that you are making a claim for within the time established for filing proofs of loss. You may download a Claim form from our web site.

Time of Payment

Claims payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of loss . We will notify you and your Provider of any additional information needed to process the claim.

To Whom Benefits Are Paid

It is not required that the service be provided by a specific Provider. Payment for services provided by a Dentegra Provider will be made directly to the Provider. Any other payments provided by this Policy will be made to you. All benefits not paid to the Provider will be payable to you, the Primary Enrollee or Dependent Enrollee, or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, benefits may be payable to his or her parent, guardian or other person actually supporting him or her.

Misstatements on Application; Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under this Policy, all statements made by you will be deemed representations and not warranties. No such statement will be used in defense to a claim under this Policy, unless it is contained in a written application.

Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to us, we would not in good faith have issued this Policy at the same premium rate. If any misstatement would materially affect the rates, we reserve the right to adjust the premium to reflect your actual circumstances at time of application.

Legal Actions

No action at law or in equity will be brought to recover on this Policy prior to expiration of 60 days after written proof of loss has been filed in accordance with requirements of this Policy, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which written proof of loss is required by this Policy.

Conformity With State Laws

All legal questions about this Policy will be governed by the state of Arkansas where this Policy was entered into and is to be performed. Any part of this Policy which, on

its Effective Date, conflicts with the laws of Arkansas is hereby amended to conform to the minimum requirements of such laws.

NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION

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

This notice is required by law to tell you how Dentegra Insurance Company ("Dentegra") protects the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's healthcare history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Dentegra receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to our administration of your benefits. However, we may change this notice and make the new notice effective for all of your PHI that we maintain. If we make any substantive changes to our privacy practices, we will promptly change this notice and redistribute to you within 60 days of the change to our practices. You may also request a copy of this notice anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Dentegra program, and we will notify you of how you can receive a copy of this notice every three years.

Permitted Uses and Disclosures of Your PHI

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or that sponsor for purposes of administering your benefits. We may disclose PHI to third parties that perform services for Dentegra in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Dentegra in the administration of your benefits. These affiliates have implemented privacy policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

Examples of Uses and Disclosures of Your PHI for Treatment, Payment or Healthcare Operations

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Additional examples include the following.

- Uses and/or disclosures of PHI in facilitating treatment.

For example, Dentegra may use or disclose your PHI to determine eligibility for services requested by your provider.

- Uses and/or disclosures of PHI for payment.

For example, Dentegra may use and disclose your PHI to bill you or your plan sponsor.

- Uses and/or disclosures of PHI for healthcare operations.

For example, Dentegra may use and disclose your PHI to review the quality of care provided by our network of providers.

Disclosures Without an Authorization

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human

Services to investigate or determine our compliance with law, and when otherwise required by law. Dentegra may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

Disclosures Dentegra Makes With Your Authorization

Dentegra will not use or disclose your PHI without your prior authorization if the law requires your authorization. You can later revoke that authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by Dentegra or by a person requesting your PHI from Dentegra.

Your Rights Regarding PHI

You have the right to request an inspection of and obtain a copy of your PHI. You may access your PHI by contacting the appropriate Dentegra office. You must include (1) your name, address, telephone number and identification number and (2) the PHI you are requesting. Dentegra may charge a reasonable fee for providing you copies of your PHI. Dentegra will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or X-rays, is returned by Dentegra to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Dentegra does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact the privacy office as noted below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

You have the right to correct or update your PHI. This means that you may request an amendment of PHI about you for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

You have the right to request or receive confidential communications from us by alternative means or at a different address. We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, another method of contact or information as to how payment will be handled. Please make this request in writing to the privacy office as noted below.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to April 14, 2003. Please contact the privacy office as noted below if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by e-mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

Complaints

You may complain to us or to the U. S. Secretary of Health and Human Services if you believe that Dentegra has violated your privacy rights. You may file a complaint with us by notifying the privacy office as noted below. We will not retaliate against you for filing a complaint.

Contact

You may contact the privacy office at the address and telephone number listed below for further information about the complaint process or any of the information contained in this notice.

Address: Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Phone: 877-280-4204

This notice is effective on and after July 1, 2006.

APPENDIX A

Benefits Summary

Coinsurance Plan

The services provided through this Policy include all the benefits described in this Benefit Summary, with the exception of those items listed in the Limitations and Exclusions, subject to our processing policies. The percentages listed are based upon the share of the Dentegra Maximum Contract Allowance paid by Dentegra (Policy Benefit Level) and the patient (Enrollee Coinsurance). The patient's share may be higher depending on the applicability of Deductibles, maximums, the difference between a Non-Dentegra Provider's fee and the Maximum Contract Allowance or the Dentegra Provider Contracted Fee or charges for non-covered services.

Primary Enrollee: [Name]

Effective Date: [XXXXX]

Plan:

You have a [Policy Year][Calendar Year] plan and deductibles and maximums will be based upon a [Policy Year][Calendar Year]. [Policy Year is the 12 months starting on the Effective Date and each subsequent 12 month period thereafter] [Calendar Year is the period of time beginning on January 1st and ending on December 31st and each subsequent 12 month period thereafter^[LK55]].

Benefits:

Policy Benefit Level

Diagnostic and Preventive Benefits:	[50 – 100 ^[LK56]]%
Basic Benefits:	[50 – 90 ^[LK57]]%
Major Benefits:	[40 - 50 ^[LK58]]%
[Orthodontic Benefits ^[LK59]	50%]

Percentages are based on the Maximum Contract Allowance.

[Standard Incentive Plan^[c60]:

Dentegra shall pay or otherwise discharge the following Policy Benefit Level of the Maximum Contract Allowance for the following services:

Plan [XX]	Paid by Dentegra during the First Year	Paid by Dentegra during the Second Year	Paid by Dentegra during the Third Year	Paid by Dentegra during the Fourth Year and thereafter
Diagnostic & Preventive Benefits[LK61]	XX%	XX%	XX%	XX%
Basic Benefits[LK62]	XX%	XX%	XX%	XX%
Major Benefits[LK63]	XX%	XX%	XX%	XX%
[Orthodontic Benefits[LK64]	XX%	XX%	XX%	XX%

Benefits will increase each year, on the anniversary of the Primary Enrollee's Effective Date, if the Enrollee utilizes the Benefits of the plan. If the plan is not utilized the benefit level will [remain at the attained level] [drop to the next lowest level] [drop to the base level]. Under no circumstances will the benefit level fall below the base benefit level. [Benefits for Enrollees with a break-in-coverage will decrease to the base level[LK65].]

[Enrollee Incentive Plan[c66]:

Dentegra shall pay or otherwise discharge the following Policy Benefit Level of the Maximum Contract Allowance for the following services:

Plan [XX]	Paid by Dentegra during the First Year	Paid by Dentegra during the Second Year	Paid by Dentegra during the Third Year	Paid by Dentegra during the Fourth year and thereafter
Diagnostic & Preventive Benefits[LK67]	XX%	XX%	XX%	XX%
Basic Benefits[LK68]	XX%	XX%	XX%	XX%
Major Benefits[LK69]	XX%	XX%	XX%	XX%
[Orthodontic Benefits[LK70]	XX%	XX%	XX%	XX%

Benefits will increase on the anniversary of the Primary Enrollee's Effective Date under this Policy. [Benefits for Enrollees with a break-in-coverage will decrease to the base level[LK71].]

Waiting Periods:[D72]

- [[Basic Benefits [d73]are limited to Enrollees who have been covered under this Policy for [12[d74]] consecutive months.] [Waiting periods are calculated for each

Primary Enrollee and/or Dependent Enrollee from the Effective Date for the Primary Enrollee and/or Dependent Enrollee.]]

[[Basic Benefits [d75] are limited to Enrollees who have been covered under this Policy for [12[d76]] consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.]]

- [[Major Benefits [d77] are limited to Enrollees who have been covered under this Policy for [12[d78]] consecutive months.] [Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date for the Primary Enrollee and/or Dependent Enrollee.]]

[[Major Benefits [d79] are limited to Enrollees who have been covered under this Policy for [12[d80]] consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.]]

- [[Orthodontic Benefits [d81] are limited to [Dependent Children of Primary Enrollees[d82]] [Primary Enrollees and their Dependents[d83]] who have been covered under this Policy for [12[d84]] consecutive months.] [Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date for the Primary Enrollee and/or Dependent Enrollee.]]

[[Orthodontic Benefits [d85] are limited to [Dependent Children of Primary Enrollees[d86]] [Primary Enrollees and their Dependents[d87]] who have been covered under this Policy for [12] [d88] consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.] [Waiting periods are calculated for each Primary Enrollee from the Effective Date for the Primary Enrollee.]]

Deductible Amount:

For each Enrollee per [Calendar Year] [Policy Year]: \$.[D89]

For each family per [Calendar Year] [Policy Year]: \$.[D90]

[The Deductible does not apply to Diagnostic and Preventive Services[d91].]

Maximum Amount:

- \$[xxx][LK92] per Enrollee per [Policy Year] [Calendar Year][LK93].
- [\$xxx][LK94] per [[Enrollee/dependent child Enrollee] per [lifetime][d95]/Policy Year] for Orthodontic Benefits.]

[The Maximum Amount does not apply to Diagnostic and Preventive Services[D96].]

Premiums:

[Per Primary Enrollee: \$ XXXX
Per Primary Enrollee with one Dependent: \$ XXXX
Per Primary Enrollee with two or more Dependents \$ ~~XXXX~~[LK97]

Premiums are to be remitted to:

Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not limited, however. And, as noted in the box below, this protection is not a substitute for consumers’ care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”) may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state.

You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract. Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act (“Act”). Below is a brief summary of the Act’s coverage’s, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone’s rights or obligations under the Act or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The

beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the law of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured's who live outside that state).
- The insurer was not authorized to do business in this state.
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to groups contract holders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plan protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an allocated annuity contract now owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;

-
- Obligation that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
 - Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNTS OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 –no matter how many policies and contracts there were with the same company, even if they provided different types of coverage's. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage's. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

Dental Insurance Rates

Please check your preferred enrollment option, billing option, plan option and payment method below. You must pay your initial enrollment payment by check, money order or credit card.

Enrollment Option

- Single Two Party
 Family (three or more)

Plan Option

- Plan [XXX]
 Plan [XXX]

Billing Option

- Annually Semi-Annually Quarterly
 Monthly EFT (Monthly Electronic Funds Transfers are processed on the [XXth] of each month. Include your first two months' payment and a blank, voided check with this form.)

Payment Method

Check/money order (**Please make payable to Dentegra Insurance Company**)

Visa®/MasterCard # _____ Exp. Date _____ **Card Code** _____ (Last three digits on signature strip on reverse of card.)

American Express # _____ Exp. Date _____ **Card Code** _____ (Four-digit number on front of card, right-hand side.)

Amount Paid \$ _____ Name as it appears on credit card _____

Signature (for credit card payment only) _____ Date _____

Enclose initial payment based on the selected payment option and coverage in the chart below.

Note: If you select EFT monthly, enclose two times the monthly rate and a voided check to begin enrollment.

Payment Frequency	Plan [XXX]			Plan [XXX]		
	Single	Two Person	Family	Single	Two Person	Family
EFT Monthly	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]
Quarterly	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]
Semi-Annually	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]
Annually	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]

The rates are valid for applicants whose coverage begins on or before XX/X/XX.

For applicants who enroll after this date, please call toll-free 1-XXX-XXX-XXXX.

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison

Signature of Applicant _____

Date _____ / _____ / _____



Outline of Coverage and Disclosure Form

Limited Benefit Health Coverage

PPO Individual and Family Dental Insurance

Read your Policy carefully. This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance Policy and only the Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is therefore important that you READ YOUR POLICY CAREFULLY. The Policy provides benefits for dental care only. It does not pay benefits for any other type of loss such as medical or hospital expenses.

If you are not satisfied with the Policy for any reason, you may return the Policy within 10 days after you receive it. Mail or deliver it to Dentegra Insurance Company. Any premium paid will be refunded. The Policy will then be void from its start.

Renewal and Premium Changes	
Renewability:	<p>The Primary Enrollee may keep the Policy in force by timely payment of the premiums or may terminate his/her coverage by providing written notice. Dentegra may refuse renewal due to:</p> <ol style="list-style-type: none"> 1) non-payment of premium; 2) fraud or material misrepresentation made by or with the knowledge of the Enrollee (or eligible dependent) applying for coverage or filing a claim for Benefits; 3) failure of the Enrollee to comply with material provisions of the Policy; or 4) Dentegra ceasing to renew all Policies issued on the same form to residents of the state where you live. <p>At least 30 days notice of any non-renewal action will be mailed to the Primary Enrollee. You may elect to not renew your coverage under the Policy by sending us written notice of your intent to terminate the Policy. Termination of the Policy and coverage for you and all Enrollees under the Policy will be effective on the last day of the month that we receive your written request of termination.</p>
[Rate Guarantee	<p>If you select a plan that contains waiting periods the initial premium rate is guaranteed for the first [12] months of continuous enrollment under the Policy, based on new enrollee premium rates in force at the time of your enrollment. After the first [12] months of enrollment, premium rates may be adjusted annually. If you move or change your enrollment options your premium rate may also change[LK1].</p>

Right to Change Premium	We may change premium annually at renewal. We will provide at least 30 days advance notice of any change in premium.	
Description of Coverage		
<p>The Policy will pay benefits shown on the Benefit Summary. These benefits are subject to Limitations and Exclusions and other terms included in the Policy. The percentages listed below are based upon the share of the Dentegra Maximum Contract Allowance paid by Dentegra (Contract Benefit Level) and your share of the cost (Enrollee Coinsurance).</p> <p>Your share of cost may be higher depending on the applicability of deductibles, maximums, the difference between a Non-Dentegra Provider's fee and the Maximum Contract Allowance or the Dentegra Provider Contracted Fee or charges for non-covered services.</p> <p>Payment for covered services performed for you by a Dentegra Provider is calculated based on the Maximum Contract Allowance, which is the lesser of the submitted fee on the claim or the Dentegra Provider's Contracted Fee. Dentegra Providers have agreed to accept the Dentegra Provider's Contracted Fee as the full charge for covered services.</p> <p>Payment for covered services performed for you by a Non-Dentegra Provider is also calculated based on the Maximum Contract Allowance. Non-Dentegra Providers do not limit their charges for services and may bill you for their normal charges, which may be higher than the Maximum Contract Allowance for the service.</p>		
Benefits ^[LK2]		
Plan ^[XX] ^[LK3]	Paid by Dentegra	Paid by Patient
Diagnostic & Preventive Benefits ^[LK4]	^{XX} ^[LK5] %	XX%
Basic Benefits	^{XX} ^[LK6] %	XX%
Major Benefits	^{XX} ^[LK7] %	XX%
[Orthodontic Benefits]	^{XX} ^[LK8] %	XX%
Deductibles and Maximums Per Enrollee		
Annual Deductible*	For each enrollee per Policy Year is ^{\$XX} ^[LK9] For each family per Policy Year is ^{\$XX} ^[LK10] [The Deductible does not apply to Diagnostic and Preventive Services ^[LK11]]	
Maximum Amount	<ul style="list-style-type: none"> • ^{\$XXX}^[LK12] per Enrollee per [Policy Year][Calendar Year^[LK13]]. • ^{\$XXX}^[LK14] per [[Enrollee/per dependent child Enrollee]per [Lifetime/Policy Year^[LK15]] for Orthodontic Benefits] [The Maximum Amount does not apply to Diagnostic and Preventive Services ^[LK16] .]	
Benefit Waiting Period	The plan option you choose may have a waiting period on some of the services (a period of time you must be enrolled before certain services are covered). Check your Benefit Summary in your Policy for any applicable waiting periods. No exceptions or credits are given for prior coverage.	

Limitations and Exclusions	
Limitations	<p>[Services limited by age, type of procedure and/or frequency include but are not limited to:</p> <ul style="list-style-type: none"> • x-rays; • exams; • cleanings; • fluoride treatment; • space maintainers; • sealants; • periodontal services; • fillings; • single crowns, inlays/onlays and cast restorations; • denture relining, rebasing or adjustments; • pupal therapy; • root canal (endodontic) treatment or retreatment; • recementation; • prosthodontic appliances or dental implants; • fixed bridge or removable dentures; • periodontal scaling and root planing; • orthodontic treatment; • dental accident; • specialist consultations[LK17];]
Exclusions	<p>[Policy exclusions include but are not limited to:</p> <ul style="list-style-type: none"> • treatment that falls under workers' compensation or employers' liability unless prohibited by law; • cosmetic dentistry or surgery procedures • maxillofacial prosthetics; • services for congenital or developmental malformations except when services provided to newborn children for medically diagnosed congenital defects or birth abnormalities; • services and/or appliances to alter the vertical dimension or restore structure loss from attrition; • any single procedure started prior to the date the Enrollee became covered under the plan; • prescription and non-prescription drugs; • experimental procedures; • charges for anesthesia, other than general anesthesia and IV sedation in connection with oral surgery or selected endodontic and periodontal surgical procedures;

<p>Exclusions</p>	<ul style="list-style-type: none"> • extraoral grafts; • interim implants; • hospitalization costs; • treatment by someone other than a provider; • plaque control programs; dietary instruction; x-ray duplications, cancer screening, tobacco counseling or broken appointments; • dental practice administrative services; • services or supplies covered by any other health plan; • treatment rendered by a person who ordinarily resides in your household or who is related to you (or to your spouse); • procedures having a questionable prognosis • Temporomandibular Joint Dysfunction treatment[LK18]; <p>The Policy limits payment to the least costly professionally accepted dental procedure</p> <p>This is a summary of the Limitations and Exclusions and is not intended to be a comprehensive listing. If you would like to receive/view a complete listing please visit our web site at www.dentegra.com or contact our Customer Service Center toll-free at 1-877-280-4204.</p>
<p>Pre-existing Condition Limitations</p>	<p>There are no pre-existing condition limitations under this Policy.</p>
<p>Eligibility</p>	
<p>Eligibility</p>	<p>At least one enrolled family member must be designated as the Primary Enrollee. Primary Enrollees electing to enroll their eligible family members must enroll them: 1) at the time the Primary Enrollee enrolls; 2) within 90 days of the Primary Enrollee’s initial enrollment; or 3) within 31 days of a Qualifying Status Change.</p> <p>Eligible family members include the Primary Enrollee’s spouse, domestic partner , and unmarried dependent children until the end of the month of their {19th} birthday (includes dependent children of the spouse or domestic partner.</p> <p>Unmarried dependent children are eligible from birth to their 19th birthday. However, an unmarried child over age 19 may remain eligible 1) up to their 25thbirthday if a full-time student in an accredited school.; or 2) if that child is incapable of self-support because of a physical disability or mental incapacity and is chiefly dependent on the Primary Enrollee for support and maintenance.</p> <p>Please contact our Customer Service Center at 1-877-280-4204 if you have any questions regarding eligibility.</p>

Enrollment Information	
[Minimum Enrollment Period]	Dentegra PPO Primary Enrollees and their dependents selecting dental coverage must enroll for a minimum of [12] months. If coverage is voluntarily discontinued, Primary Enrollees and their covered family members may not re-enroll during the [12]-month period immediately following the voluntary termination[LK19].]
Enrollment Grace Period	There is a period of 10 days from your coverage effective date which you may rescind this Policy and receive a full refund, provided you and all enrolled family members have not used any benefits under this Policy.

IMPORTANT: In the event of any inconsistency between this Outline of Coverage and the Policy, the terms of the Policy will control.

Premium Information		
Premiums for the Dentegra PPO Plan are based on the prevailing dental costs in the region where you live (based on your ZIP code), your choice of three enrollment options: single-party enrollment, two-party enrollment, or a family enrollment of three or more persons, and your choice of Plan.		
Your Selection	Plan Option	[XX[LK20]]
	Enrollment Option	[Individual[LK21]]
	Payment Frequency:	[Monthly[LK22]]
	Premium Payment	[\$XX.XX[LK23]]

Underwritten and Insured by:
Dentegra Insurance Company

P.O. Box 1809
Alpharetta, GA 30023-1809
Toll Free Member Services Telephone Number: 877-280-4204
Web Site: [www.dentegra.com]

SERFF Tracking Number: WESA-126545262
 Filing Company: Dentegra Insurance Company
 Company Tracking Number: I-PPO-C-AR-09
 TOI: H101 Individual Health - Dental
 Product Name: Dentegra PPO
 Project Name/Number: Dentegra PPO/I-PPO-C-AR-09

State: Arkansas
 State Tracking Number: 45491
 Sub-TOI: H101.000 Health - Dental

Rate Information

Rate data applies to filing.

Filing Method:

Rate Change Type:

Neutral

Overall Percentage of Last Rate Revision:

0.000%

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Dentegra Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking Number: WESA-126545262

State: Arkansas

Filing Company: Dentegra Insurance Company

State Tracking Number: 45491

Company Tracking Number: I-PPO-C-AR-09

TOI: H101 Individual Health - Dental

Sub-TOI: H101.000 Health - Dental

Product Name: Dentegra PPO

Project Name/Number: Dentegra PPO/I-PPO-C-AR-09

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Please find readability certificate attached. Attachment: Arkansas Readability Certificate 4-22-10.pdf	Approved-Closed	07/09/2010
Satisfied - Item: Application Comments: Please find the application attached. Attachment: EF-I-ST-09 4-12-10.pdf	Approved-Closed	07/09/2010
Satisfied - Item: Outline of Coverage Comments: Outline of Coverage is attached. Attachment: OOC-I-PPO-AR-2010 4-15-10.pdf	Approved-Closed	07/09/2010
Satisfied - Item: Statements of Variability Comments: Please find statements of variability attached. Attachments: SV-PPO-I-AR-09 4-15-10.pdf SV-PPO-I-OOC-AR-10 4-15-10.pdf	Approved-Closed	07/09/2010

<i>SERFF Tracking Number:</i>	<i>WESA-126545262</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Dentegra Insurance Company</i>	<i>State Tracking Number:</i>	<i>45491</i>
<i>Company Tracking Number:</i>	<i>I-PPO-C-AR-09</i>		
<i>TOI:</i>	<i>H101 Individual Health - Dental</i>	<i>Sub-TOI:</i>	<i>H101.000 Health - Dental</i>
<i>Product Name:</i>	<i>Dentegra PPO</i>		
<i>Project Name/Number:</i>	<i>Dentegra PPO/I-PPO-C-AR-09</i>		

		Item Status:	Status
			Date:
Satisfied - Item:	Letter of Authorization	Approved-Closed	07/09/2010
Comments:	Please find letter of authorization attached.		
Attachment:	Letter of Authorization.pdf		

		Item Status:	Status
			Date:
Satisfied - Item:	Redline Policy	Approved-Closed	07/09/2010
Comments:	Redlined Policy is attached.		
Attachment:	I-PPO-C-AR-09 Redline 4-28-10.pdf		

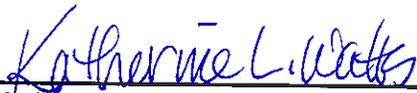
READABILITY CERTIFICATION

To Whom It May Concern:

This is to certify that the attached forms achieved a Flesch Reading Ease Score and are in compliance with applicable laws and regulations as follows:

Form #	Title	Flesch Score
I-PPO-C-AR-09	Dentegra PPO Policy	51.5
EF-I-ST-09	Dentegra PPO Individual/Family Dental Insurance Application	56.9
OOC-I-PPO-2010- AR	Dentegra PPO Outline of Coverage	47.1

Dentegra Insurance Company



Katherine L. Watts
VP Legal & Regulatory and Assistant
Secretary

April 23, 2010

Date

Dental Insurance Rates

Please check your preferred enrollment option, billing option, plan option and payment method below. You must pay your initial enrollment payment by check, money order or credit card.

Enrollment Option

- Single Two Party
 Family (three or more)

Plan Option

- Plan [XXX]
 Plan [XXX]

Billing Option

- Annually Semi-Annually Quarterly
 Monthly EFT (Monthly Electronic Funds Transfers are processed on the [XXth] of each month. Include your first two months' payment and a blank, voided check with this form.)

Payment Method

- Check/money order (**Please make payable to Dentegra Insurance Company**)

Visa®/MasterCard # _____ Exp. Date _____ **Card Code** _____ (Last three digits on signature strip on reverse of card.)

American Express # _____ Exp. Date _____ **Card Code** _____ (Four-digit number on front of card, right-hand side.)

Amount Paid \$ _____ Name as it appears on credit card _____

Signature (for credit card payment only) _____ Date _____

Enclose initial payment based on the selected payment option and coverage in the chart below.

Note: If you select EFT monthly, enclose two times the monthly rate and a voided check to begin enrollment.

Payment Frequency	Plan [XXX]			Plan [XXX]		
	Single	Two Person	Family	Single	Two Person	Family
EFT Monthly	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]
Quarterly	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]
Semi-Annually	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]
Annually	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]

The rates are valid for applicants whose coverage begins on or before XX/X/XX.

For applicants who enroll after this date, please call toll-free 1-XXX-XXX-XXXX.

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison

Signature of Applicant _____

Date _____ / _____ / _____



Outline of Coverage and Disclosure Form

Limited Benefit Health Coverage

PPO Individual and Family Dental Insurance

Read your Policy carefully. This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance Policy and only the Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is therefore important that you READ YOUR POLICY CAREFULLY. The Policy provides benefits for dental care only. It does not pay benefits for any other type of loss such as medical or hospital expenses.

If you are not satisfied with the Policy for any reason, you may return the Policy within 10 days after you receive it. Mail or deliver it to Dentegra Insurance Company. Any premium paid will be refunded. The Policy will then be void from its start.

Renewal and Premium Changes	
Renewability:	<p>The Primary Enrollee may keep the Policy in force by timely payment of the premiums or may terminate his/her coverage by providing written notice. Dentegra may refuse renewal due to:</p> <ol style="list-style-type: none"> 1) non-payment of premium; 2) fraud or material misrepresentation made by or with the knowledge of the Enrollee (or eligible dependent) applying for coverage or filing a claim for Benefits; 3) failure of the Enrollee to comply with material provisions of the Policy; or 4) Dentegra ceasing to renew all Policies issued on the same form to residents of the state where you live. <p>At least 30 days notice of any non-renewal action will be mailed to the Primary Enrollee. You may elect to not renew your coverage under the Policy by sending us written notice of your intent to terminate the Policy. Termination of the Policy and coverage for you and all Enrollees under the Policy will be effective on the last day of the month that we receive your written request of termination.</p>
[Rate Guarantee	<p>If you select a plan that contains waiting periods the initial premium rate is guaranteed for the first [12] months of continuous enrollment under the Policy, based on new enrollee premium rates in force at the time of your enrollment. After the first [12] months of enrollment, premium rates may be adjusted annually. If you move or change your enrollment options your premium rate may also change[LK1].</p>

Right to Change Premium	We may change premium annually at renewal. We will provide at least 30 days advance notice of any change in premium.	
Description of Coverage		
<p>The Policy will pay benefits shown on the Benefit Summary. These benefits are subject to Limitations and Exclusions and other terms included in the Policy. The percentages listed below are based upon the share of the Dentegra Maximum Contract Allowance paid by Dentegra (Contract Benefit Level) and your share of the cost (Enrollee Coinsurance).</p> <p>Your share of cost may be higher depending on the applicability of deductibles, maximums, the difference between a Non-Dentegra Provider's fee and the Maximum Contract Allowance or the Dentegra Provider Contracted Fee or charges for non-covered services.</p> <p>Payment for covered services performed for you by a Dentegra Provider is calculated based on the Maximum Contract Allowance, which is the lesser of the submitted fee on the claim or the Dentegra Provider's Contracted Fee. Dentegra Providers have agreed to accept the Dentegra Provider's Contracted Fee as the full charge for covered services.</p> <p>Payment for covered services performed for you by a Non-Dentegra Provider is also calculated based on the Maximum Contract Allowance. Non-Dentegra Providers do not limit their charges for services and may bill you for their normal charges, which may be higher than the Maximum Contract Allowance for the service.</p>		
Benefits ^[LK2]		
Plan ^[XX] ^[LK3]	Paid by Dentegra	Paid by Patient
Diagnostic & Preventive Benefits ^[LK4]	^{XX} ^[LK5] %	XX%
Basic Benefits	^{XX} ^[LK6] %	XX%
Major Benefits	^{XX} ^[LK7] %	XX%
[Orthodontic Benefits]	^{XX} ^[LK8] %	XX%
Deductibles and Maximums Per Enrollee		
Annual Deductible*	For each enrollee per Policy Year is ^{\$XX} ^[LK9] For each family per Policy Year is ^{\$XX} ^[LK10] [The Deductible does not apply to Diagnostic and Preventive Services ^[LK11]]	
Maximum Amount	<ul style="list-style-type: none"> • ^{\$XXX}^[LK12] per Enrollee per [Policy Year][Calendar Year^[LK13]]. • ^{\$XXX}^[LK14] per [[Enrollee/per dependent child Enrollee]per [Lifetime/Policy Year^[LK15]] for Orthodontic Benefits] [The Maximum Amount does not apply to Diagnostic and Preventive Services ^[LK16] .]	
Benefit Waiting Period	The plan option you choose may have a waiting period on some of the services (a period of time you must be enrolled before certain services are covered). Check your Benefit Summary in your Policy for any applicable waiting periods. No exceptions or credits are given for prior coverage.	

Limitations and Exclusions	
Limitations	<p>[Services limited by age, type of procedure and/or frequency include but are not limited to:</p> <ul style="list-style-type: none"> • x-rays; • exams; • cleanings; • fluoride treatment; • space maintainers; • sealants; • periodontal services; • fillings; • single crowns, inlays/onlays and cast restorations; • denture relining, rebasing or adjustments; • pupal therapy; • root canal (endodontic) treatment or retreatment; • recementation; • prosthodontic appliances or dental implants; • fixed bridge or removable dentures; • periodontal scaling and root planing; • orthodontic treatment; • dental accident; • specialist consultations[LK17];]
Exclusions	<p>[Policy exclusions include but are not limited to:</p> <ul style="list-style-type: none"> • treatment that falls under workers' compensation or employers' liability unless prohibited by law; • cosmetic dentistry or surgery procedures • maxillofacial prosthetics; • services for congenital or developmental malformations except when services provided to newborn children for medically diagnosed congenital defects or birth abnormalities; • services and/or appliances to alter the vertical dimension or restore structure loss from attrition; • any single procedure started prior to the date the Enrollee became covered under the plan; • prescription and non-prescription drugs; • experimental procedures; • charges for anesthesia, other than general anesthesia and IV sedation in connection with oral surgery or selected endodontic and periodontal surgical procedures;

<p>Exclusions</p>	<ul style="list-style-type: none"> • extraoral grafts; • interim implants; • hospitalization costs; • treatment by someone other than a provider; • plaque control programs; dietary instruction; x-ray duplications, cancer screening, tobacco counseling or broken appointments; • dental practice administrative services; • services or supplies covered by any other health plan; • treatment rendered by a person who ordinarily resides in your household or who is related to you (or to your spouse); • procedures having a questionable prognosis • Temporomandibular Joint Dysfunction treatment[LK18]; <p>The Policy limits payment to the least costly professionally accepted dental procedure</p> <p>This is a summary of the Limitations and Exclusions and is not intended to be a comprehensive listing. If you would like to receive/view a complete listing please visit our web site at www.dentegra.com or contact our Customer Service Center toll-free at 1-877-280-4204.</p>
<p>Pre-existing Condition Limitations</p>	<p>There are no pre-existing condition limitations under this Policy.</p>
<p>Eligibility</p>	
<p>Eligibility</p>	<p>At least one enrolled family member must be designated as the Primary Enrollee. Primary Enrollees electing to enroll their eligible family members must enroll them: 1) at the time the Primary Enrollee enrolls; 2) within 90 days of the Primary Enrollee’s initial enrollment; or 3) within 31 days of a Qualifying Status Change.</p> <p>Eligible family members include the Primary Enrollee’s spouse, domestic partner , and unmarried dependent children until the end of the month of their {19th} birthday (includes dependent children of the spouse or domestic partner.</p> <p>Unmarried dependent children are eligible from birth to their 19th birthday. However, an unmarried child over age 19 may remain eligible 1) up to their 25thbirthday if a full-time student in an accredited school.; or 2) if that child is incapable of self-support because of a physical disability or mental incapacity and is chiefly dependent on the Primary Enrollee for support and maintenance.</p> <p>Please contact our Customer Service Center at 1-877-280-4204 if you have any questions regarding eligibility.</p>

Enrollment Information	
[Minimum Enrollment Period]	Dentegra PPO Primary Enrollees and their dependents selecting dental coverage must enroll for a minimum of [12] months. If coverage is voluntarily discontinued, Primary Enrollees and their covered family members may not re-enroll during the [12]-month period immediately following the voluntary termination[LK19].]
Enrollment Grace Period	There is a period of 10 days from your coverage effective date which you may rescind this Policy and receive a full refund, provided you and all enrolled family members have not used any benefits under this Policy.

IMPORTANT: In the event of any inconsistency between this Outline of Coverage and the Policy, the terms of the Policy will control.

Premium Information		
Premiums for the Dentegra PPO Plan are based on the prevailing dental costs in the region where you live (based on your ZIP code), your choice of three enrollment options: single-party enrollment, two-party enrollment, or a family enrollment of three or more persons, and your choice of Plan.		
Your Selection	Plan Option	[XX[LK20]]
	Enrollment Option	[Individual[LK21]]
	Payment Frequency:	[Monthly[LK22]]
	Premium Payment	[\$XX.XX[LK23]]

Underwritten and Insured by:
Dentegra Insurance Company

P.O. Box 1809
Alpharetta, GA 30023-1809
Toll Free Member Services Telephone Number: 877-280-4204
Web Site: [www.dentegra.com]

DENTEGRA INSURANCE COMPANY
STATEMENT OF VARIABILITY FOR
DENTEGRA POLICY -- FORM I-PPO-C-AR-09

The following lettered/numbered and bracketed points correspond to the letters/number text next to bracketed text in the above referenced form. Bracketed text in above referenced form is variable and the below information is provided as guidance as to when bracketed text is used in the form.

- [c1] Use when PPO/PPO
- [c2] Use when PPO/Program Allowance
- [c3] This sentence is used when the plan is based on a Policy Year basis.
- [c4] Minimum enrollment period is variable. Offering could be without minimum enrollment period or could be with minimum enrollment period of less than or greater than 12 months. If there is a minimum enrollment period then the standard is 12 months.
- [LK5] Waiting period is variable and language included in this section will be adjusted to include if the Enrollee must wait 12 months before they can apply for coverage again.
- [c6] This section is included if the offering has a waiting period. Waiting period time frame may vary dependent on plan option and will be included in Benefits Summary (Appendix A).
- [c7] Use if sealants are covered under D&P rather than the standard Basic. If covered as standard Basic this item would be deleted.
- [c8] Standard is Basic; but could offer as Major or not a benefit.
- [c9] Standard is Basic; but may be offered as Major or not a benefit.
- [c10] Standard is Basic; but may be offered as Major or not a benefit.
- [LK11] Standard is Basic; or not a benefit.
- [c12] Use if sealants are covered under Basic rather than D&P.
- [c13] Standard is Basic; but may be offered as Major or D&P or not a benefit.
- [c14] Standard is Basic; but may be offered as Major or not a benefit.
- [c15] Standard is Basic; but could offer as Major or not a benefit.
- [c16] Standard is Basic; but could offer as Major or not a benefit.
- [LK17] Standard is Major or not a benefit.

- [c18] Standard is Basic; but could offer as Major or not a benefit.
- [c19] Standard is Major or not a benefit.
- [c20] Standard is Major; or not a benefit.
- [LK21] Standard is Major or not a benefit.
- [LK22] Standard is Major, or not a benefit.
- [c23] Standard is 12 months but option could be for a Policy Year.
- [LK24] Twice in any twelve month period is standard however frequency is variable based on plan design.
- [c25] If periodontal is covered as other than Basic, this sentence will be changed accordingly.
- [c26] Five years is standard; however 3 years may be an option.
- [c27] Once each 12 months for Enrollees 18 and older and twice each 12 months for Enrollees under 18 is standard; however offering could have a different number of x-rays.
- [c28] Standard is to cover fluoride to age 19; however, could offer another age or could have no limitation and cover all (delete limitation if all covered).
- [C29] 14 is standard but another age may be offered.
- [c30] Sealants can be offered as either D&P or as Basic.

Use if sealants are covered under D&P rather than the standard Basic. If sold as standard Basic benefit this item would be deleted.
- [c31] These are standard age and time limits for sealants but they may vary.
- [c32] Sealants can be offered as either D&P or as Basic. Use if sealants are covered under standard Basic. If sold as D&P this item would be deleted.
- [C33] These are standard age and time limits for sealants but they may vary.
- [c34] Standard time is 24 months but could vary.
- [c35] Standard is to cover as Major; however could be offered as Basic.
- [c36] Include if Endodontics covered under Basic. Move to "Limitations on Major Benefits" if covered under Major.
- [c37] Include if Periodontics covered under Basic. Move to "Limitations on Major Benefits" if covered under Major. Standard surgery limitation is 3 years.

- [c38] Standard options for crown and inlay/onlay restoration time limits are 5 or 9 year
- [c39] Standard options for prosthodontic time limits are 5 or 9 years.
- [c40] Include this exclusion if missing teeth are not covered. Delete this exclusion if missing teeth are covered.
- [LK41] Lifetime is standard; however, Policy Year could be an option.
- [c42] Standard is two (2) payments – 50% initial and 50% at 12 months but other frequencies could be offered.
- [c43] Use if Ortho Benefit is covered for children only.
- [c44] Standard is to include composite wording here; however, some offerings could cover composite restorations on posterior teeth.
- [D45] Include this exclusion if missing teeth are not covered. Delete this exclusion if missing teeth are covered.
- [D46] Would be included if plan did not cover Oral Surgery, General Anesthesia, Palliative Treatment or sealants; otherwise, deleted. Changes would be made if plan does not exclude all services.
- [D47] Would be included if Applicant did not want to cover endodontics; otherwise, wording deleted.
- [D48] Would be included if Applicant did not want to cover periodontics; otherwise, wording deleted.
- [D49] Would be included if Applicant did not want to cover restorative treatment; otherwise, wording deleted
- [D50] Would be included if Applicant did not want to cover denture repairs; otherwise, wording deleted.
- [D51] Would be included if Applicant did not want to cover crowns, cast restorations and inlays/onlays otherwise, wording deleted.
- [D52] Would be included if Applicant did not want to cover prosthodontics; otherwise, wording deleted.
- [LK53] Would be included if Major Services are not covered.
- [c54] Rate guarantee is optional and time frame for rate guarantee will vary dependent on plan selection.
- [LK55] Standard is Policy Year, but option could be for a Calendar Year.
- [LK56] Percentage covered is variable from 50 – 100% in increments of 10%
- [LK57] Percentage covered is variable from 50 – 90% in increments of 10% or

not a benefit.

- [LK58] Percentage covered is variable from 40 to 50% in increments of 10% or not a benefit.
- [LK59] Covered under Major at 50% or not a benefit.
- [c60] Use if applicant chooses Standard Incentive Plan option. Delete if either no incentive plan chosen or if Enrollee Incentive Plan chosen.
- [LK61] Percentage covered is variable from 50 – 100% in increments of 10%
- [LK62] Percentage covered is variable from 50 – 90% in increments of 10% or not a benefit.
- [LK63] Percentage covered is variable from 40 to 50% in increments of 10% or not a benefit.
- [LK64] Covered under Major at 50% or not a benefit.
- [LK65] Language may be included dependent on plan design.
- [c66] Use if applicant chooses Enrollee Incentive Plan option. Delete if either no incentive plan chosen or if Standard Incentive Plan chosen.
- [LK67] Percentage covered is variable from 50 – 100% in increments of 10%
- [LK68] Percentage covered is variable from 50 – 90% in increments of 10% or not a benefit.
- [LK69] Percentage covered is variable from 40 to 50% in increments of 10% or not a benefit.
- [LK70] Covered under Major at 50% or not a benefit.
- [LK71] Language may be included dependent on plan design
- [D72] Include if waiting periods apply; otherwise, delete. Time period option for all waiting periods is 0 to 24 months.
- [d73] Standard – dependent waiting period is determined by his/her own length of coverage.
- [d74] Time period options for all waiting periods is 0 months to 24 months.
- [d75] Nonstandard – dependent waiting period is tied to Primary Enrollee's length of coverage
- [d76] Time period options for all waiting periods is 0 months to 24 months.
- [d77] Standard – dependent waiting period is determined by his/her own length of coverage.
- [d78] Time period options for all waiting periods is 0 months to 24 months.

- [d79] Nonstandard – dependent waiting period is tied to Primary Enrollee’s length of coverage.
- [d80] Time period options for all waiting periods is 0 months to 24 months.
- [d81] Standard – dependent waiting period is determined by his/her own length of coverage.
- [d82] Use if only dependent children are covered under Orthodontic Benefits.
- [d83] Use if adults and children are covered under Orthodontic Benefits.
- [d84] Time period options for all waiting periods is 0 months to 24 months.
- [d85] Nonstandard – dependent waiting period is tied to Primary Enrollee’s length of coverage
- [d86] Use if only dependent children are covered under Orthodontic Benefits.
- [d87] Use if adults and children are covered under Orthodontic Benefits.
- [d88] Time period options for all waiting periods is 0 months to 24 months.
- [D89] Will be taken from approved Application. Ranges are \$25-\$250 in increments of \$25.
- [D90] Will be taken from approved Application. Ranges are \$25-\$500 in increments of \$25.
- [d91] Will be included if Deductible is waived.
- [LK92] Plan annual maximum ranges from \$1000 - \$5000 in increments of \$100.
- [LK93] Standard is Policy Year, but option could be for a Calendar Year.
- [LK94] Include if Orthodontic is a covered service. Orthodontic services may have a separate lifetime maximum which ranges from \$1000 - \$1500 in increments of \$100.
- [d95] Lifetime is standard; however, Policy Year could be an option.
- [D96] Would be used when Applicant purchases the option where D&P Services do not apply towards the Enrollee's yearly maximum. Standard would be not to include this.
- [LK97] Premiums will vary dependent on plan selection and zip code of residence of Primary Enrollee. Rates are submitted to the Department as required by regulation.

DENEGRA INSURANCE COMPANY

STATEMENT OF VARIABILITY FOR

DENEGRA OUTLINE OF COVERAGE -- FORM OOC-I-PPO-AR-2010

Bracketed text in the above referenced form is variable. The following lettered/numbered and bracketed text correspond to the letters/number text next to bracketed text in the above referenced form.

- [LK1] Rate guarantee is optional and time frame for rate guarantee will vary dependent on plan selection.
- [LK2] Standard Incentive Plan or Enrollee Incentive Plan options are available. Dependent on Individual selection this section of the Outline of Coverage would be replaced to include the stepped waiting periods. See example below:

Benefits				
Plan [XX][LK3]	Paid by Dentegra during the First Year	Paid by Dentegra during the Second Year	Paid by Dentegra during the Third Year	Paid by Dentegra during the Fourth year and thereafter
Diagnostic & Preventive Benefits [LK4] [LK5]	XX%	XX%	XX%	XX%
Basic Benefits[LK6]	XX%	XX%	XX%	XX%
Major Benefits[LK7]	XX%	XX%	XX%	XX%
[Orthodontic Benefits [LK8]	XX%	XX%	XX%	XX%

- [LK3] Benefits provided under the Plan will vary based on Individuals selection.
- [LK4] Deductible may be waived for Diagnostic and Preventative services.
- [LK5] Percentage covered is variable from 50 – 100% in increments of 10%
- [LK6] Percentage covered is variable from 50 – 90% in increments of 10% or not a benefit.
- [LK7] Percentage covered is variable from 40 to 50% in increments of 10% or not a benefit.
- [LK8] Covered under Major at 50% or not a benefit.
- [LK9] Will be taken from approved Application. Ranges are \$25-\$250 in increments of \$25.
- [LK10] Will be taken from approved Application. Ranges are \$25 - \$500 in increments of \$25.
- [LK11] Would be used when Applicant purchases the option where D&P Services do not apply towards the Enrollee's yearly maximum. Standard would be not to include this.

- [LK12] Plan annual maximum ranges from \$1000 - \$5000 in increments of \$100.
- [LK13] Standard is Policy Year, but option could be for a Calendar Year.
- [LK14] Include if Orthodontic is a covered service. Orthodontic services may have a separate lifetime maximum which ranges from \$1000 - \$1500 in increments of \$100.
- [LK15] Standard is Policy Year, but option could be for a Calendar Year.
- [LK16] Would be used when Applicant purchases the option where D&P Services do not apply towards the Enrollee's yearly maximum. Standard would be not to include this.
- [LK17] Limitations will be dependent on plan selection and will be variable. Listing included in this Outline of Coverage are standard limitations.
- [LK18] Exclusions will be dependent on plan selection and will be variable. Listing included in this Outline of Coverage are standard exclusions.
- [LK19] Minimum enrollment is variable. Offering could be without minimum enrollment or could be with minimum enrollment of less than or greater than 12 months. If there is a minimum enrollment period then the standard is 12 months. [LK17] Plan selection is variable and will be populated based on individual's selection
- [LK20] Plan Option selected by Applicant will be provided here.
- [LK21] Enrollment option is variable and will be populated based on individual selection. Options available: Individual, Individual plus one dependent, or Individual plus two or more dependents.
- [LK22] Payment frequency is variable and will be populated based on individual selection. Options available may include Monthly EFT, Quarterly, Semi-annual and Annual.
- [LK23] Premium payment is variable and will be populated based on Applicants plan selection.



March 5, 2010

Dentegra Insurance Company
FEIN#: 75-1233841
NAIC#: 73474

Letter of Authorization
Filing of Forms, Rates and Rules

Dear Sir or Madame:

In accordance with the applicable statutes and regulations in your state, Darcy Lebau and Westmont Associates are hereby authorized to file form, rate and rate filings on behalf of Dentegra Insurance Company.

Very truly yours,

A handwritten signature in blue ink that reads "Katherine L. Watts".

Katherine L. Watts
VP Legal & Regulatory and Assistant Secretary





Dentegra Dental PPO for Individuals and Families



www.dentegra.com

Policy

Your dental plan is underwritten by Dentegra Insurance Company (“Dentegra”). Dentegra will pay Benefits for covered dental services as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first installment of premium. It takes effect on the Effective Date shown on the Benefits Summary attached to this Policy. This Policy will remain in force unless otherwise terminated in accordance with its terms, until the first renewal date and for such further periods for which it is renewed. All periods will begin and end at 12:01 A.M., Standard Time, where you live.

READ YOUR POLICY AND BENEFITS SUMMARY CAREFULLY

**This Policy is a legal agreement between the Primary Enrollee and
Dentegra Insurance Company**

10-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

Please read this Policy. If you are not satisfied for any reason, you may return this Policy within 10 days after you received it. Mail or deliver it to Dentegra or the agent through whom it was purchased. Any premium paid will be refunded. This Policy will then be void from its start.

This Policy is signed for Dentegra Insurance Company, as of its Effective Date by:



Anthony S. Barth, Vice Chairman

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INTRODUCTION

We are pleased to welcome you to this individual Dentegra PPO dental plan. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the dentist, but to see him/her on a regular basis.

Using This Policy

This Policy discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the dental plan works and how to obtain dental care. Please read this Policy completely and carefully. Keep in mind that “you” and “your” mean the Enrollees who are covered under this plan. “We, “us” and “our” always refer to Dentegra.

Contact Us

If you have any questions about your coverage that are not answered here, please visit our web site at www.dentegra.com or call our Customer Service Center. A Customer Service representative can answer questions you may have about obtaining dental care, help you locate a Dentegra Provider, explain benefits, check the status of a claim, and assist you in filing a claim.

You can access our automated information line at 877-280-4204 during regular business hours to obtain information about Enrollee benefits, claim status or to speak to a Customer Service representative for assistance. If you prefer to write to us with your question(s) please mail your inquiry to the following address:

Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Identification Number

Please provide the Primary Enrollee’s ID number to your Provider whenever you or one of your enrolled family members receives dental services. The Enrollee ID number should be included on all claims submitted for payment. Identification cards are not required, but if you wish to have one you may obtain one by visiting our web site at www.dentegra.com.

DEFINITIONS

The following are definitions of words that have special or technical meanings under this Policy.

Accepted Fee: the amount the attending Provider agrees to accept as payment in full for services rendered.

Benefits (In-Network or Out-of-Network): the amounts that Dentegra will pay for dental services under this Policy. In-Network Benefits are those covered by this Policy and performed by a Dentegra Provider. Out-of-Network Benefits are those covered by this Policy but performed by a Non-Dentegra Provider.

Benefit Waiting Period: the period of time of continuous enrollment that an Enrollee must complete before certain dental procedures become covered benefits.

Calendar Year: the period of time beginning on January 1st and ending on December 31st.

Claim Form: the standard form used to file a claim or request a Pre-Treatment Estimate.

Deductible: a dollar amount that an Enrollee and/or the Enrollee's family (for family coverage) must pay for certain covered services before Dentegra begins paying benefits.

Dentegra PPO Provider (Dentegra Provider): a Provider who contracts with Dentegra and agrees to accept the Dentegra Contracted Fee as payment in full for services provided under a PPO plan. A Dentegra Provider also agrees to comply with Dentegra's administrative guidelines.

Dentegra PPO Provider's Contracted Fee (Dentegra Provider Contracted Fee): the fee for each Single Procedure that a Dentegra Provider has contractually agreed to accept as payment in full for treating Enrollees.

Dependent Enrollee: an Eligible Dependent enrolled to receive Benefits.

Effective Date: The date the plan starts. This date is given in your Benefits Summary.

Eligible Dependent: a dependent of the Primary Enrollee or domestic partner eligible for Benefits.

Enrollee: an individual who made application for this dental Policy ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits; may also be referred to as "Patient".

Maximum Contract Allowance: the reimbursement under the Enrollee's benefit plan against which Dentegra calculates its payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- [by a Dentegra Provider is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee; or
- by a Non-Dentegra Provider is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee for a Dentegra Provider in the same geographic [area](#)^[c1].]

- [by a Dentegra Provider is the lesser of the Submitted Fee on the claim or the Dentegra Provider's Contracted Fee; or
- by a Non-Dentegra Provider is the lesser of the Submitted Fee on the claim or the Program [Allowance](#)^[c2].]

Non-Dentegra Provider: a Provider who is not a Dentegra Provider, is not contractually bound to abide by Dentegra's administrative guidelines and has not agreed to accept the Dentegra Contracted Fees.

Patient Pays: Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Dentegra Pays" on the claims statement when a claim is processed.

Policy: this contract of insurance issued and delivered to the Enrollee. It includes the application, any attached amendments, and any appendices.

Policy Benefit Level: the percentage of Maximum Contract Allowance that Dentegra will pay after the Deductible has been satisfied.

Policy Term: the period during which the Policy is in effect.

Policy Year: the 12 months starting on the Effective Date and each subsequent 12-month period thereafter. [Deductibles and maximums will be determined using this 12-month period rather than on a Calendar Year [basis](#)^[c3].]

Premium: the amount payable by the Enrollee as provided in the Benefits Summary.

Pre-Treatment Estimate: an estimation of the allowable Benefits under this Policy for the services proposed, assuming the person is an eligible Enrollee.

Primary Enrollee: the individual insured in this plan to receive Benefits.

Procedure Code: the Current Dental Terminology (CDT)[®] number assigned to a Single Procedure by the American Dental Association.

Program Allowance: the amount determined by a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area.

Provider: a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

Single Procedure: a dental procedure that is assigned a separate CDT© number.

Submitted Fee: the amount that the Provider bills and enters on a claim for a specific procedure.

ELIGIBILITY AND ENROLLMENT

Eligibility Requirement

Primary Enrollees electing to enroll their eligible family members must enroll them at the time the Primary Enrollee enrolls or within 90 days of the Primary Enrollees initial enrollment or within 31 days of a Qualifying Status Change.

Eligible family members include:

- Your spouse or domestic partner.
- Your unmarried dependent children from birth to their 19th birthday or 25th birthday, if a full-time student in an accredited school. Proof of full-time student status must be given to us within 60 days when requested. “Children” includes natural children, step-children, adopted children, children of your domestic partner, foster children and children for which you have been appointed legal guardian. The child must be dependent on you for support. Newborn infants are eligible from the moment of birth. Adopted children are eligible from the date a petition is filed if you apply for coverage within 60 days after the filing of the petition or from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the minor.
- Your unmarried children 19 years or older may continue to be eligible as a dependent if the child is incapable of self-sustaining employment due to mental incapacity or physical handicap that began before age 19 and the child is chiefly dependent on you for support and maintenance. ~~Proof of these facts must be given to us within 31 days if it is requested.~~ Proof will not be required more than once a year after the child is 21.

Dependents serving active military duty are not eligible, as they are typically covered under health and dental insurance provided by the military while they are on active duty.

Qualifying Status Change is a change in:

- Legal marital status (marriage, divorce, legal separation, annulment or death); or
- Number of dependents (a child’s birth, adoption of a child, placement of a child for adoption; addition of a step or foster child or death of a child); or
- A loss of coverage under a provision dental benefits plan for reasons other than exceeding the annual or lifetime maximum benefits and provided that coverage existed for 90 continuous days without a break in coverage of more than 63 days; or

-
- A dependent child ceases to satisfy eligibility requirements (limiting age or marital status); or
 - A court order requiring dependent coverage.

The additional Premium must be paid to us within 31 days after the date of the Qualifying Status Change in order to have the coverage continued beyond the 31 day period.

Enrollment Grace Period

There is a period of 10 days from your coverage Effective Date during which you may rescind this Policy and receive a full refund, provided you and all enrolled family members have not used any Benefits under this Policy.

[Minimum Enrollment Period

You and your covered family members selecting dental coverage must enroll for a minimum of [12] months. If coverage is voluntarily discontinued, you and your covered family members may not re-apply during the [12]-month period immediately following the voluntary termination^{[c4].}

RENEWABLE - PREMIUM MAY CHANGE CONDITIONALLY:

The Primary Enrollee may keep this Policy in force by timely payment of the premiums. However, Dentegra may refuse renewal due to:

- 1) Non-payment of premiums, subject to the “Grace Period on Late Payment” provision; or
- 2) Fraud or material misrepresentation made by or with the knowledge of the Primary Enrollee or an Eligible Dependent applying for this coverage or filing a claim for Benefits; or
- 3) The Primary Enrollee fails to comply with material provisions of this Policy; or
- 4) The company ceasing to renew all Policies issued on this form to residents of the state where you live.

At least 30 days notice of any non-renewal action permitted by this clause will be mailed to the Primary Enrollee at your last address as shown in Dentegra’s records. If Dentegra fails to provide 30 days notice of our intent to terminate coverage, your coverage will remain in effect until 30 days after notice is given or until the effective date of replacement coverage, whichever occurs first. However, no Benefits will be paid for expenses incurred during any period of time for which premium has not been paid.

Dentegra will provide 30 days advance written notice of any change in premium at renewal.

Termination of Coverage

You have the right to terminate your coverage under this Policy by sending us written notice of your intent to terminate this Policy. Termination of this Policy and coverage for you and all Enrollees under this Policy will be effective on the last day of the month that we receive your written request of termination.

A full refund of premium is available if a written request for a refund is made within the first 10 days of the Effective Date. After that, all requests for a premium refund will be prorated based upon the number of months remaining in the Policy Term, subject to the following exceptions:

- 1) A refund is not available if you or your Dependent Enrollee have received Benefits under this Policy;
- 2) There must be at least one month remaining in the Policy Term. Since coverage is based on a full calendar month, there are no partial month refunds.
- 3) Your Dependent Enrollee may disenroll from coverage under this Policy at any time. Termination of coverage for the disenrolled dependent shall occur on the last day of the month we receive written notice of the Enrollee's disenrollment. Coverage for your Dependent Enrollee will automatically terminate on the last day of the month in which the Enrollee no longer meets eligibility requirements.

We have the right to terminate this Policy and your coverage if you fail to pay your Premium or if your Premium payment is not received by us by the 31st day following the date it is due. Please see the section titled "Grace Period on Late Payments" for more information.

We also have the right to terminate your coverage:

- Upon 15 days written notice if you:
 - Are guilty of misconduct detrimental to safe operations and the delivery of services while in a Dentegra Provider's facility; or
 - Knowingly commit or permit another person to commit fraud or deception in obtaining Benefits.
- Upon 30 days written notice if you fail to pay coinsurance; provided however, that you may be reinstated during the Policy Term upon payment of all delinquent charges.

If your coverage is terminated, we will send a written notice to you informing you of the reason(s) why coverage is terminated and the date that your coverage will end. However, coverage will continue for 31 days to complete any Single Procedure begun but not completed before the Effective Date of termination.

In the event of termination or death of the insured, unearned premiums shall be paid in lump sum on a date no later than thirty (30) days after the proof of the insured's death has been furnished to us.

Reinstatement

If you do not pay your premium within the time granted for payment, your Policy will be terminated. If your Policy is terminated you [may re-enroll in the program and any waiting period, deductibles and maximum applicable to your program will start again.] [must wait [12] months before re-enrolling in the program and any waiting periods, deductible and maximums applicable to your program will start again^[LK5].] However, your Policy may be reinstated with no break in coverage provided the full premium due is received by us within 60 days of the date of the past due premium. The reinstated Policy will have the same rights as before your Policy lapsed, unless a change is made to your Policy in connection with the reinstatement. These changes, if any, will be sent to you for you to attach to your Policy.

OVERVIEW OF DENTAL BENEFITS

This section provides information that will give you a better understanding of how this dental plan works and how to make it work best for you.

[Benefit Waiting Period

Some of the services in your dental plan are subject to a waiting period. Please refer to your Benefits Summary (Appendix A). No exceptions or credits are given for prior coverage. Enrollees who terminate from the dental plan and later re-apply will be required to satisfy another [12]-month waiting period during the new enrollment with no credit for prior enrollment^[c6].

Benefits, Limitations and Exclusions

We will pay the Benefits for the types of dental services as described below. We will pay Benefits only for covered services. The services provided through this Policy are described in the Benefits Summary. This Policy covers several categories of benefits when a Provider furnishes the services and when they are necessary and within the standards of generally accepted dental practice. Claims shall be processed in accordance with our standard processing policies. We may use dentists (dental

consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Policy. Even if the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

Enrollee Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services, as shown in the Benefits Summary, subject to certain limitations, and you are responsible for paying the balance. What you pay is called the enrollee coinsurance (“Enrollee Coinsurance”) and is part of your out-of-pocket cost. You pay this even after a Deductible has been met.

The amount of your Enrollee Coinsurance will depend on the type of service and the Provider furnishing the service (see section titled “Selecting Your Provider”). Providers are required to collect Enrollee Coinsurance for covered services. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to you, we will be obligated to provide as Benefits only the applicable percentages of the Provider’s fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

It is to your advantage to select Dentegra Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to the sections titled “Selecting Your Provider” and “How Claims Are Paid” for more information.

Deductible

Your dental plan features a Deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The Deductible amounts are listed in the Benefits Summary. Deductibles apply to all benefits unless otherwise noted. Only the Provider’s fees you pay for covered Benefits will count toward the Deductible.

Maximum Amount

Your dental program has a maximum dollar amount we will pay toward the cost of dental care (“Maximum Amount”). You are responsible for paying costs above this amount. The Maximum Amount payable is shown in the Benefits Summary. Maximums may apply on a yearly basis, a per services basis, or a lifetime basis.

Benefits

To help you understand the types of procedures that are included in each category, the following is a description of each of the categories of services that are covered under this Policy.

We will pay the Policy Benefit Level shown in the Benefits Summary for the following services:

Diagnostic and Preventive Benefits:

- Diagnostic: procedures to assist the Provider in choosing required dental treatment.
- Preventive: cleaning [(periodontal cleaning in the presence of inflamed gums is considered to be a Basic Benefit for payment purposes)], topical application of fluoride solutions, and space maintainers.
- [Sealants: topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay^[c7].]

[Basic Benefits:

- [Oral Surgery: extractions and other surgical procedures (including pre- and post-operative care^[c8]).
- General Anesthesia or IV Sedation: when administered by a Provider for oral surgery or selected endodontic and periodontal surgical procedures.
- Anesthesia and hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a hospital or ambulatory surgical facility if the Provider certifies that, because of the Enrollee's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the patient is:
 - 1) a child under seven (7) years of age who is determined by two (2) licensed dentists to require, without delay, necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; or
 - 2) a person with a diagnosed serious mental or physical condition; or
 - 3) a person with a significant behavioral problem as determined by your licensed Provider.
- [Endodontics: treatment of diseases and injuries of the tooth pulp^[c9].]
- [Periodontics: treatment of gums and bones supporting teeth^[c10].]

-
- [Palliative: treatment to relieve [pain](#)^[LK11].]
 - [Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing [decay](#)^[c12].]
 - [Restorative: amalgam, synthetic porcelain, plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of [decay](#)^[c13]).]
 - [Denture Repairs: repair to partial or complete dentures including rebase procedures and [relining](#)^[c14].]

[Major Benefits:

- [Oral Surgery: extractions and other surgical procedures (including pre- and post-operative [care](#)^[c15]).]
- [Endodontics: treatment of diseases and injuries of the tooth [pulp](#)^[c16].]
- [Orthodontic: procedures performed by a Provider using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their [function](#)^[LK17]]
- [Periodontics: treatment of gums and bones supporting [teeth](#)^[c18].]
- [Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain or plastic [restorations](#)^[c19].]
- [Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; [implant surgical placement and removal; and for implant supported prosthetics, including implant repair and [recementation](#)^[c20].]
- [Implants: procedures performed by a Provider for endodontic endosseous, endosteal, eposteal and transosteal implants; implant connecting bars and implant repairs. Implants are defined as prosthetic applicances placed into or on the bone of the maxilla or mandible (upper or lower jaw) to retain or support dental [prosthesis](#)^[LK21]]
- [Dental Accident: An injury to the mouth or structures within the oral cavity which is caused by an external traumatic force. It does not include damage to the teeth which is the result of biting into food or other substances. Procedures shall include but are not limited to reimplantation, splinting and [stayplate](#)^[LK22].]

Note on additional Benefits during pregnancy: When an Enrollee is pregnant, we will pay for additional services during the pregnancy. The additional services each [12 month^{c23} period] [Policy Year] while the Enrollee is covered under this Policy include: one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

Limitations and Exclusions

Dental plans are designed to help with part of your dental expenses and may not always cover every dental need. The typical program includes Limitations and Exclusions, meaning the program does not cover every aspect of dental care. This can relate to the type of procedures or the number of visits. Please read the following sections to help you understand the Limitations and Exclusions of this dental plan.

Limitations

Benefits to Enrollees are limited as follows:

Limitations on Diagnostic and Preventive Benefits:

- We will pay for routine oral examinations (including any office visits for observation and specialist consultations, or combination thereof), cleanings (including periodontal cleanings or any combination thereof) and topical application of fluoride solutions no more than [twice^{LK24}] in any 12 month period. Note that periodontal cleanings are covered as a [Basic Benefit] and^{c25} routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional benefits during pregnancy.
- Specialist consultations are only a Benefit when an opinion or advice is requested by a general dentist and the treatment is not performed by the specialist.
- X-ray limitations:
 - a) Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
 - b) When a panoramic film is submitted with supplemental film(s), Dentegra will limit the total reimbursable amount to the Accepted Fee for a complete intraoral series.

-
- c) If a panoramic film is taken in conjunction with an intraoral complete series, Dentegra considers the panoramic film to be included in the complete series.
 - d) A complete intraoral series and panoramic films by the same Provider/Provider office are limited to once each every [five (5)] years^[c26].
 - e) Bitewing x-rays are limited to [two (2) times in any 12 month period] when provided to Enrollees under 18 and [one (1) time each 12 months] for Enrollees age 18 and over. Bitewings are not a Benefit within six (6) months of an intraoral complete series unless warranted by special circumstances such as active periodontal disease or rampant caries^[c27].
 - [Topical application of fluoride solutions is limited to Enrollees to age 19^[c28].]
 - Space maintainers are limited to the initial appliance and are a benefit for an Enrollee under age [14^[c29]]. For Enrollees ages 14 and 15, an allowance for a space maintainer will be considered until a fixed bridges or removable partial dentures can be placed.
 - Cephalometric x-rays, oral/facial photographic images (once per case) and diagnostic casts (once per case) are benefits only in conjunction with orthodontic services and only when orthodontic services are a covered Benefit.
 - [Sealants are limited as follows^[c30]:
 - a) to permanent first molars through age [eight (8)] and to permanent second molars through age [15] if they are without caries (decay) or restorations on the occlusal surface.
 - b) do not include repair or replacement of a sealant on any tooth within [two (2)] years of its application^[c31].]

Limitations on Basic Benefits:

- [Sealants are limited as follows^[c32]:
 - a) to permanent first molars through age [eight (8)] and to permanent second molars through age [15] if they are without caries (decay) or restorations on the occlusal surface.
 - b) do not include repair or replacement of a sealant on any tooth within [two (2)] years of its application^[c33].]
- We will not pay to replace an amalgam, synthetic porcelain or plastic restorations (fillings) or prefabricated resin and stainless steel crowns within [24 months^[c34]] of treatment if the service is provided by the same Provider.

-
- We limit payment for prefabricated resin and stainless steel crowns under this section to services on baby (deciduous) teeth. However, after a consultant's review, we may allow stainless steel crowns on permanent teeth as a [Major Benefit^[c35].]
 - [Retreatment of root canal therapy within 24 months of the initial procedure is not a Benefit when performed by the same Provider^[c36].]
 - [Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing.] See note on additional Benefits during pregnancy^[c37].
 - Extractions and oral surgery procedures performed for Orthodontic treatment are not a Benefit except as provided under Orthodontic Benefits, if applicable.

Limitations on Major Benefits:

- Crowns, inlays/onlays and cast restorations are covered no more often than once in any [five (5) year period] except when we determine the existing crown, or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues^[c38].
- Prosthodontic appliances and/or implants that were provided under any Dentegra program will be replaced only after [five (5) years^[c39]] have passed, except when we determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Dentegra program will be made if we determine it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Dentegra's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Dentegra or any other dental care plan.
- When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.
- Recementation of crowns, inlays/onlays or bridges is not a Benefit when performed by the same Provider within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation.
- [The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is

made necessary by natural, permanent teeth extraction occurring during a time you were eligible under a Dentegra program^[c40].

- We limit payment for dentures to a standard partial or denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care and rebase (including relining and any adjustments) for the first six (6) months after placement. Additional Denture benefit limitations are:
 - a) Denture rebase is limited to one (1) per arch in a 24 month period.
 - b) Denture relines and tissue conditioning are limited to two (2) per arch in a 12 month period. Tissue conditioning provided on the same day a denture is delivered or a reline or rebase has been performed is not a Benefit.
- The Orthodontic Benefit maximum amount payable for each Enrollee during the Enrollee's [lifetime][Policy Year^[LK41]] is shown in the Benefits Summary. Additional Orthodontic benefit limitations are:
 - a) Orthodontic Benefits will be provided in two (2) payments after the person becomes covered, (one initial payment and the second in twelve (12) months), except for treatment plans of less than \$500 which will be paid in one (1) payment^[c42].
 - b) Orthodontic Benefits are not paid to repair or replace any orthodontic appliance received under this program.
 - c) Non-Orthodontic procedures performed for the purpose of Orthodontic treatment are subject to the Orthodontic Benefit and maximum if covered as Benefits under Dentegra's standard processing policies.
 - d) Orthodontic Benefits are limited to dependent child Enrollees under the age of 19^[c43].
- Implant Benefits are subject to all the Limitations, Exclusions and other terms and conditions in this Policy. Additional implant benefit limitations are:
 - a) Diagnostic and treatment facilitating aids are considered a part of, and included in, the fees for the definitive treatment.
 - b) Bone graphs provided for implants on the same day as service.
- Dental Accident Benefits are subject to all the Limitations, Exclusions and other terms and conditions in this Policy. Additional Dental Accident benefit limitations are:
 - a) The dental accident must occur while you are covered under this Policy.

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- b) Services and procedures must be provided within 180 days following the dental accident and while you are covered under this Policy.

Limitations on All Benefits - Optional Services:

Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called “Optional Services”. Optional Services also include the use of specialized techniques instead of standard procedures. For example:

- A Crown where a filling would restore the tooth; or
- a precision denture/partial where a standard denture/partial could be used; or
- an Inlay/Onlay instead of an amalgam restoration; or
- porcelain, resin or similar materials for Crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a full metal crown) [; or/.]
- [a composite restoration instead of an amalgam restoration on posterior teeth^[c44].]

If you receive Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. You will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

Exclusions

This Policy covers a wide variety of dental care expenses, but there are some services for which we do not provide benefits. It is important for you to know what these services are before you visit your Provider.

We do not pay benefits for:

- Treatment of injuries or illness covered by workers’ compensation or employers’ liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- Cosmetic surgery or procedures for purely cosmetic reasons.
- Maxillofacial prosthetics.
- Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those

services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.

- Treatment to restore tooth structure lost from wear, erosion, or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize teeth. Examples include but are not limited to: equilibration, periodontal splinting, occlusal adjustments or occlusal guards.
- Single surface restorations placed on the same surface as a sealant and within 12 months of the initial sealant application or multiple surface restorations placed on the same surface as a sealant and within six (6) months of the initial sealant application.
- Any Single Procedure started prior to the date the Enrollee became covered under this plan.
- Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental procedures.
- Charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed Provider in connection with oral surgery or selected endodontic and periodontal surgical procedures, except as allowed under Basic Benefits.
- Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- Porcelain and porcelain fused to metal crowns for Enrollees under age 12.
- Fixed bridges and removable partials for Enrollees under age 16.
- Interim implants.
- Resin-based inlays and onlays.
- Overdentures.
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- Treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments.
- Dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary

materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

- Services or supplies covered by any other health plan.
- Treatment rendered by a person who ordinarily resides in your household or who is related to you (or to your spouse) by blood, marriage or legal adoption.
- Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- [The initial placement of any prosthodontic appliance or implants unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under this Policy or was covered under any dental care program with Dentegra. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth[D45].]
- Services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Major Benefit section, if applicable.
- Procedures performed for the purpose of orthodontic treatment are not a Benefit except as provided under Major Benefits, if applicable.
- Services for any disturbance of the temporomandibular (jaw) joints or associated musculature, nerves and other tissues (TMJ).
- [Services or supplies for oral surgery, general anesthesia, palliative treatment, or sealants[D46].]
- [Services or supplies for endodontic treatment[D47] (procedures for removal of the nerve of the tooth and the treatment of the pulp cavity portion of the root of the tooth).]
- [Services or supplies for periodontic treatment (procedures for the treatment of the gums and the bones supporting teeth[D48]).]
- [Services or supplies for restorative treatment (amalgam, synthetic porcelain, plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).][D49]
- [Services or supplies for denture repairs (repair to partial or complete dentures including rebase procedures and relining.)][D50]
- [Services or supplies for crowns, cast restorations, inlays/onlays for treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain, plastic restorations.][D51]

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- [Services or supplies for prosthodontic benefits (procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges.)][D52]
 - [Services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures][LK53].]

Pre-Treatment Estimates

Pre-treatment estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. We will estimate the amount of Benefits payable under this Policy for the listed services. By asking your Provider for a Pre-Treatment Estimate from us before you agree to receive any prescribed treatment, you will have an estimate up front of what we will pay and the difference you will need to pay. The Benefits will be processed according to the terms of this Policy when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days, or until an earlier occurrence of any one of the following events:

- 1) the date this Policy terminates;
- 2) the date the Dependent Enrollee's coverage ends; or
- 3) the date the Provider's agreement with Dentegra ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if you are covered and meet all the requirements of the plan at the time the treatment you have planned is completed and may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

SELECTING YOUR PROVIDER

Free Choice of Provider

We recognize that many factors affect the choice of Provider and therefore support your right to freedom of choice regarding your Provider. This assures that you have full access to the dental treatment you need from the dental office of your choice. You may see any Provider for your covered treatment, whether the Provider is a Dentegra Provider or a Non-Dentegra Provider. In addition, you and your family members can see different Providers.

Remember, you enjoy the greatest benefits—including out-of-pocket savings—when you choose a Dentegra Provider. To take full advantage of your benefits, we highly recommend you verify a dentist's participation status within a Dentegra network with your dental office before each appointment. Review the section titled "How Claims

Are Paid” for an explanation of Dentegra payment procedures to understand the method of payments applicable to your Provider selection and how that may impact your out-of-pocket costs.

Locating a Dentegra Provider

You may access information through our web site at www.dentegra.com. You may also call our Customer Service Center and one of our representatives will assist you. We can provide you with information regarding a Provider’s network, specialty and office location.

HOW CLAIMS ARE PAID

Payment for Services — Dentegra Provider

Payment for covered services performed for you by a Dentegra Provider is calculated based on the Maximum Contract Allowance, which is the lesser of the submitted fee on the claim or the Dentegra Provider’s Contracted Fee. Dentegra Providers have agreed to accept the Dentegra Provider’s Contracted Fee as the full charge for covered services.

The portion of the Maximum Contract Allowance payable by us is limited to the applicable Policy Benefit Level shown in the Benefits Summary. Dentegra’s payment is sent directly to the Dentegra Provider who submitted the claim. We advise you of any charges not payable by us for which you are responsible. These charges are generally your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

Payment for Services — Non-Dentegra Provider

Payment for services performed for you by a Non-Dentegra Provider is also calculated based on the Maximum Contract Allowance. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Policy Benefit Level shown in the Benefits Summary.

However, when dental services are received from a Non-Dentegra Provider, Dentegra’s Payment is sent directly to the Primary Enrollee. You are responsible for payment of the Non-Dentegra Provider’s Submitted Fee. Non-Dentegra Providers will bill you for their normal charges, which may be higher than the Maximum Contract Allowance for the service. You may be required to pay the Provider yourself and then submit a claim to us for reimbursement. Since our payment for services you receive may be less than the Non-Dentegra Provider’s actual charges, your out-of-pocket cost may be significantly higher.

How to Submit a Claim

Claims for Benefits must be filed on a standard Claim Form, which most dental offices have available. Dentegra Providers will fill out and submit your claims paperwork for you. Some Non-Dentegra Providers may also provide this service upon your request. If you receive services from a Non-Dentegra Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled “Claim Form” for more information.

Your dental office should be able to assist you in filling out the claim form. Fill out the claim form completely and send it to:

Dentegra Insurance Company

P.O. Box 1809

Alpharetta, GA 30023-1809

Payment Guidelines

We do not pay Dentegra Providers any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If you or your Provider files a claim for services more than 12 months after the date you received the services, payment may be denied. If the services were received from a Non-Dentegra Provider, you are still responsible for the full cost. If the payment is denied because your Dentegra Provider failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your Dentegra Provider that you were covered under a Dentegra Policy at the time you received the service, you may be responsible for the cost of that service.

We explain to all Dentegra Providers how we determine or deny payment for services. We describe in detail the dental procedures covered as benefits, the conditions under which coverage is provided and the plan’s limitations and exclusions. If any services are not covered, or if limitations or exclusions apply to services you have received, you may be responsible for the full payment.

If you have any questions about any dental charges, processing policies and/or how your claim is paid, please contact us.

PREMIUM PAYMENT RESPONSIBILITIES

The Primary Enrollee is responsible for making premium payments, paying Deductibles and Enrollee Coinsurance and ensuring your Provider is aware of any other dental coverage you carry. These are explained in detail in the following subsections.

[Rate Guarantee

For plans with waiting periods, your initial premium rate is guaranteed for the first two years of continuous coverage under your Policy, based upon the new enrollee rates in force at the time you apply for coverage. After the first two years, premium rates may be adjusted annually. If you move, or change your enrollment options, your premium rate may also **change**^[c54].

Premium Billing

When you completed your application, you selected your dental benefits and the method for paying your ongoing premiums, either by check or through Electronic Funds Transfer (EFT). The following is a description of how each of these methods works.

Pay by Check

If you selected to pay by check, you also selected the option of paying your premiums quarterly, semi-annually or annually.

If you elected to pay your premiums quarterly, semi-annually, or annually, you will receive an invoice once every billing period.

Your payment must be received by the 20th of the month in which it is due to ensure coverage for the following billing period. All payments are to be mailed to the following address:

Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Pay by Electronic Funds Transfer (EFT)

If you chose to pay your premium on a monthly basis through monthly EFT, Dentegra will transfer the premium payment from your bank account at the end of each month for the following month's coverage.

If funds aren't available, your account will be considered delinquent.

If the account continues to be delinquent for more than 31 days, your Policy will be terminated.

Changing Payment Options

Payment options may be changed at any time; however, the effective date of the change varies dependent on your payment option. Changes to EFT, quarterly and semi-annual

payment options are effective on the anniversary or semi-anniversary of your Policy Effective Date. Changes to the annual payment option are effective on the anniversary of your Policy Effective Date. To change your payment option you can call our Customer Service Center toll-free at 877-280-4204 during regular business hours or write to the Customer Service Center at:

Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023

Grace Period on Late Payments

If your premium payment is not received by the first of the month a grace period of 31 days will be granted. During the grace period the Policy shall continue in force.

If the account continues to be delinquent for more than 31 days, your Policy will be terminated.

COMPLAINTS AND APPEALS

Our commitment to you is to ensure quality throughout the entire dental benefit process: from the courtesy extended to you by our Customer Service representatives to the dental services provided by Dentegra Providers. If you have questions about any services received, we recommend that you first discuss the matter with your Provider. However, if you continue to have concerns, please call our Customer Service Center. You can also e-mail questions by accessing the “Contact Us” section of our web site at www.dentegra.com.

Complaints regarding eligibility, the denial of dental services or claims, the policies, procedures, or operations of Dentegra, or the quality of dental services performed by the Provider may be directed in writing to us or by calling us toll-free at 877-280-4204.

When you write, please include the name of the Enrollee, the Primary Enrollee’s name and ID number, and your telephone number on all correspondence. You should also include a copy of the claim form, claim statement, or other relevant information. Your claim statement will have an explanation of the claim review and any complaint process and time limits applicable to such process.

We will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. You and your Provider have at least 180 days after receiving a notice of denial to request a review by writing to Dentegra giving reasons why you believe the denial was wrong. You may also ask

Dentegra to examine any additional information you include that may support your complaint.

Send your complaint to us at the address shown below:

Dentegra Insurance Company

P.O. Box 1809

Alpharetta, GA 30023

We will send you a written acknowledgment within 5 days upon receipt of your complaint. We will make a full and fair review within 30 days after we receive the complaint. We may ask for more documents if needed. We will send you a decision within 30 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of this Policy, we shall consult with a dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual.

Appeals

If you believe you need further review of your claim and/or your complaint, you may contact your state insurance regulatory agency.

PROVISIONS REQUIRED BY LAW

Entire Contract; Changes

This Policy, including the endorsements and the attached papers, constitutes the entire contract of insurance. No change to this Policy shall be valid until approved by our executive officer and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

Incontestability

After 3 years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by you in the application for this Policy will be used to void the Policy or to deny a claim for loss incurred or disability commencing after the expiration of such 3-year period.

No claim for loss incurred or disability commencing after 3 years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical

condition not excluded from coverage by name or specific description effective on the date of loss has existed prior to the effective date of this Policy.

Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, you as may be required to administer the claim, or have you be examined by a dental consultant retained by us, at our own expense, in or near your community or residence. We will in every case hold such information and records confidential.

Written Notice of Claim/Proof of Loss

We must be given written proof of loss within 12 months after the date of the loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give written proof in the time required, provided that the proof is filed as soon as reasonably possible. A notice of claim submitted by you, on your behalf, or on behalf of your beneficiary to us or to our authorized agent, with information sufficient to identify you will be considered notice of claim.

All written proof of loss must be given to us within 12 months of the termination of this Policy.

Send your Notice of Claim/Proof of Loss to us at the address shown below:

Dentegra Insurance Company

P.O. Box 1809

Alpharetta, GA 30023

Claim Form

We will, within 15 days after receiving a notice of a claim, provide you or your Provider with a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If we do not send you or your provider a claim form within 15 days after you or your Provider gave us notice regarding a claim, the requirements for proof of loss outlined in the section "Written Notice of Claim/Proof of Loss" above will be deemed to have been complied with as long as you give us written proof that explains the type and the

extent of the loss that you are making a claim for within the time established for filing proofs of loss. You may download a Claim form from our web site.

Time of Payment

Claims payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of loss . We will notify you and your Provider of any additional information needed to process the claim.

To Whom Benefits Are Paid

It is not required that the service be provided by a specific Provider. Payment for services provided by a Dentegra Provider will be made directly to the Provider. Any other payments provided by this Policy will be made to you. All benefits not paid to the Provider will be payable to you, the Primary Enrollee or Dependent Enrollee, or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, benefits may be payable to his or her parent, guardian or other person actually supporting him or her.

Misstatements on Application; Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under this Policy, all statements made by you will be deemed representations and not warranties. No such statement will be used in defense to a claim under this Policy, unless it is contained in a written application.

Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to us, we would not in good faith have issued this Policy at the same premium rate. If any misstatement would materially affect the rates, we reserve the right to adjust the premium to reflect your actual circumstances at time of application.

Legal Actions

No action at law or in equity will be brought to recover on this Policy prior to expiration of 60 days after written proof of loss has been filed in accordance with requirements of this Policy, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which written proof of loss is required by this Policy.

Conformity With State Laws

All legal questions about this Policy will be governed by the state of Arkansas where this Policy was entered into and is to be performed. Any part of this Policy which, on

its Effective Date, conflicts with the laws of Arkansas is hereby amended to conform to the minimum requirements of such laws.

NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION

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

This notice is required by law to tell you how Dentegra Insurance Company ("Dentegra") protects the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's healthcare history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Dentegra receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to our administration of your benefits. However, we may change this notice and make the new notice effective for all of your PHI that we maintain. If we make any substantive changes to our privacy practices, we will promptly change this notice and redistribute to you within 60 days of the change to our practices. You may also request a copy of this notice anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Dentegra program, and we will notify you of how you can receive a copy of this notice every three years.

Permitted Uses and Disclosures of Your PHI

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or that sponsor for purposes of administering your benefits. We may disclose PHI to third parties that perform services for Dentegra in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Dentegra in the administration of your benefits. These affiliates have implemented privacy policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

Examples of Uses and Disclosures of Your PHI for Treatment, Payment or Healthcare Operations

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Additional examples include the following.

- Uses and/or disclosures of PHI in facilitating treatment.

For example, Dentegra may use or disclose your PHI to determine eligibility for services requested by your provider.

- Uses and/or disclosures of PHI for payment.

For example, Dentegra may use and disclose your PHI to bill you or your plan sponsor.

- Uses and/or disclosures of PHI for healthcare operations.

For example, Dentegra may use and disclose your PHI to review the quality of care provided by our network of providers.

Disclosures Without an Authorization

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human

Services to investigate or determine our compliance with law, and when otherwise required by law. Dentegra may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

Disclosures Dentegra Makes With Your Authorization

Dentegra will not use or disclose your PHI without your prior authorization if the law requires your authorization. You can later revoke that authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by Dentegra or by a person requesting your PHI from Dentegra.

Your Rights Regarding PHI

You have the right to request an inspection of and obtain a copy of your PHI. You may access your PHI by contacting the appropriate Dentegra office. You must include (1) your name, address, telephone number and identification number and (2) the PHI you are requesting. Dentegra may charge a reasonable fee for providing you copies of your PHI. Dentegra will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or X-rays, is returned by Dentegra to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Dentegra does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact the privacy office as noted below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

You have the right to correct or update your PHI. This means that you may request an amendment of PHI about you for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

You have the right to request or receive confidential communications from us by alternative means or at a different address. We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, another method of contact or information as to how payment will be handled. Please make this request in writing to the privacy office as noted below.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to April 14, 2003. Please contact the privacy office as noted below if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by e-mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

Complaints

You may complain to us or to the U. S. Secretary of Health and Human Services if you believe that Dentegra has violated your privacy rights. You may file a complaint with us by notifying the privacy office as noted below. We will not retaliate against you for filing a complaint.

Contact

You may contact the privacy office at the address and telephone number listed below for further information about the complaint process or any of the information contained in this notice.

Address: Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Phone: 877-280-4204

This notice is effective on and after July 1, 2006.

APPENDIX A

Benefits Summary

Coinsurance Plan

The services provided through this Policy include all the benefits described in this Benefit Summary, with the exception of those items listed in the Limitations and Exclusions, subject to our processing policies. The percentages listed are based upon the share of the Dentegra Maximum Contract Allowance paid by Dentegra (Policy Benefit Level) and the patient (Enrollee Coinsurance). The patient's share may be higher depending on the applicability of Deductibles, maximums, the difference between a Non-Dentegra Provider's fee and the Maximum Contract Allowance or the Dentegra Provider Contracted Fee or charges for non-covered services.

Primary Enrollee: [Name]

Effective Date: [XXXXX]

Plan:

You have a [Policy Year][Calendar Year] plan and deductibles and maximums will be based upon a [Policy Year][Calendar Year]. [Policy Year is the 12 months starting on the Effective Date and each subsequent 12 month period thereafter] [Calendar Year is the period of time beginning on January 1st and ending on December 31st and each subsequent 12 month period thereafter^[LK55]].

Benefits:

Policy Benefit Level

Diagnostic and Preventive Benefits:	[50 – 100 ^[LK56]]%
Basic Benefits:	[50 – 90 ^[LK57]]%
Major Benefits:	[40 – 50 ^[LK58]]%
[Orthodontic Benefits ^[LK59]	50%]

Percentages are based on the Maximum Contract Allowance.

[Standard Incentive Plan^[c60]:

Dentegra shall pay or otherwise discharge the following Policy Benefit Level of the Maximum Contract Allowance for the following services:

Plan [XX]	Paid by Dentegra during the First Year	Paid by Dentegra during the Second Year	Paid by Dentegra during the Third Year	Paid by Dentegra during the Fourth Year and thereafter
Diagnostic & Preventive Benefits[LK61]	XX%	XX%	XX%	XX%
Basic Benefits[LK62]	XX%	XX%	XX%	XX%
Major Benefits[LK63]	XX%	XX%	XX%	XX%
[Orthodontic Benefits[LK64]	XX%	XX%	XX%	XX%

Benefits will increase each year, on the anniversary of the Primary Enrollee's Effective Date, if the Enrollee utilizes the Benefits of the plan. If the plan is not utilized the benefit level will [remain at the attained level] [drop to the next lowest level] [drop to the base level]. Under no circumstances will the benefit level fall below the base benefit level. [Benefits for Enrollees with a break-in-coverage will decrease to the base level[LK65].]

[Enrollee Incentive Plan[c66]:

Dentegra shall pay or otherwise discharge the following Policy Benefit Level of the Maximum Contract Allowance for the following services:

Plan [XX]	Paid by Dentegra during the First Year	Paid by Dentegra during the Second Year	Paid by Dentegra during the Third Year	Paid by Dentegra during the Fourth year and thereafter
Diagnostic & Preventive Benefits[LK67]	XX%	XX%	XX%	XX%
Basic Benefits[LK68]	XX%	XX%	XX%	XX%
Major Benefits[LK69]	XX%	XX%	XX%	XX%
[Orthodontic Benefits[LK70]	XX%	XX%	XX%	XX%

Benefits will increase on the anniversary of the Primary Enrollee's Effective Date under this Policy. [Benefits for Enrollees with a break-in-coverage will decrease to the base level[LK71].]

Waiting Periods:[D72]

- [[Basic Benefits [d73]are limited to Enrollees who have been covered under this Policy for [12[d74]] consecutive months.] [Waiting periods are calculated for each

Primary Enrollee and/or Dependent Enrollee from the Effective Date for the Primary Enrollee and/or Dependent Enrollee.]]

[[Basic Benefits [d75] are limited to Enrollees who have been covered under this Policy for [12[d76]] consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.]]

- [[Major Benefits [d77] are limited to Enrollees who have been covered under this Policy for [12[d78]] consecutive months.] [Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date for the Primary Enrollee and/or Dependent Enrollee.]]

[[Major Benefits [d79] are limited to Enrollees who have been covered under this Policy for [12[d80]] consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.]]

- [[Orthodontic Benefits [d81] are limited to [Dependent Children of Primary Enrollees[d82]] [Primary Enrollees and their Dependents[d83]] who have been covered under this Policy for [12[d84]] consecutive months.] [Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective for the Primary Enrollee and/or Dependent Enrollee.]]

[[Orthodontic Benefits [d85] are limited to [Dependent Children of Primary Enrollees[d86]] [Primary Enrollees and their Dependents[d87]] who have been covered under this Policy for [12] [d88] consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee's length of coverage.] [Waiting periods are calculated for each Primary Enrollee from the Effective Date for the Primary Enrollee.]]

Deductible Amount:

For each Enrollee per [Calendar Year] [Policy Year]: \$.[D89]

For each family per [Calendar Year] [Policy Year]: \$.[D90]

[The Deductible does not apply to Diagnostic and Preventive Services[d91].]

Maximum Amount:

- \$[xxx][LK92] per Enrollee per [Policy Year] [Calendar Year][LK93].
- [\$xxx][LK94] per [[Enrollee/dependent child Enrollee] per [lifetime][d95]/Policy Year] for Orthodontic Benefits.]

[The Maximum Amount does not apply to Diagnostic and Preventive Services[D96].]

Premiums:

[Per Primary Enrollee: \$ XXXX
Per Primary Enrollee with one Dependent: \$ XXXX
Per Primary Enrollee with two or more Dependents \$ ~~XXXX~~[LK97]

Premiums are to be remitted to:

Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not limited, however. And, as noted in the box below, this protection is not a substitute for consumers’ care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”) may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state.

You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract. Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association

c/o The Liquidation Division

1023 West Capitol

Little Rock, Arkansas 72201

Arkansas Insurance Department

1200 West Third Street

Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act (“Act”). Below is a brief summary of the Act’s coverage’s, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone’s rights or obligations under the Act or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The

beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the law of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured's who live outside that state).
- The insurer was not authorized to do business in this state.
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to groups contract holders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plan protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an allocated annuity contract now owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;

-
- Obligation that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
 - Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNTS OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 –no matter how many policies and contracts there were with the same company, even if they provided different types of coverage's. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage's. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

<i>SERFF Tracking Number:</i>	<i>WESA-126545262</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Dentegra Insurance Company</i>	<i>State Tracking Number:</i>	<i>45491</i>
<i>Company Tracking Number:</i>	<i>I-PPO-C-AR-09</i>		
<i>TOI:</i>	<i>H101 Individual Health - Dental</i>	<i>Sub-TOI:</i>	<i>H101.000 Health - Dental</i>
<i>Product Name:</i>	<i>Dentegra PPO</i>		
<i>Project Name/Number:</i>	<i>Dentegra PPO/I-PPO-C-AR-09</i>		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
04/19/2010	Form	Dentegra PPO Policy	07/09/2010	I-PPO-C-AR-09 4-15-10.pdf (Superseded)



Dentegra Dental PPO for Individuals and Families



www.dentegra.com

Policy

Your dental plan is underwritten by Dentegra Insurance Company (“Dentegra”). Dentegra will pay Benefits for covered dental services as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first installment of premium. It takes effect on the Effective Date shown on the Benefits Summary attached to this Policy. This Policy will remain in force unless otherwise terminated in accordance with its terms, until the first renewal date and for such further periods for which it is renewed. All periods will begin and end at 12:01 A.M., Standard Time, where you live.

READ YOUR POLICY AND BENEFITS SUMMARY CAREFULLY

**This Policy is a legal agreement between the Primary Enrollee and
Dentegra Insurance Company**

10-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

Please read this Policy. If you are not satisfied for any reason, you may return this Policy within 10 days after you received it. Mail or deliver it to Dentegra or the agent through whom it was purchased. Any premium paid will be refunded. This Policy will then be void from its start.

This Policy is signed for Dentegra Insurance Company, as of its Effective Date by:



Anthony S. Barth, Vice Chairman

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INTRODUCTION

We are pleased to welcome you to this individual Dentegra PPO dental plan. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the dentist, but to see him/her on a regular basis.

Using This Policy

This Policy discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the dental plan works and how to obtain dental care. Please read this Policy completely and carefully. Keep in mind that “you” and “your” mean the Enrollees who are covered under this plan. “We, “us” and “our” always refer to Dentegra.

Contact Us

If you have any questions about your coverage that are not answered here, please visit our web site at www.dentegra.com or call our Customer Service Center. A Customer Service representative can answer questions you may have about obtaining dental care, help you locate a Dentegra Provider, explain benefits, check the status of a claim, and assist you in filing a claim.

You can access our automated information line at 877-280-4204 during regular business hours to obtain information about Enrollee benefits, claim status or to speak to a Customer Service representative for assistance. If you prefer to write to us with your question(s) please mail your inquiry to the following address:

Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Identification Number

Please provide the Primary Enrollee’s ID number to your Provider whenever you or one of your enrolled family members receives dental services. The Enrollee ID number should be included on all claims submitted for payment. Identification cards are not required, but if you wish to have one you may obtain one by visiting our web site at www.dentegra.com.

DEFINITIONS

The following are definitions of words that have special or technical meanings under this Policy.

Accepted Fee: the amount the attending Provider agrees to accept as payment in full for services rendered.

Benefits (In-Network or Out-of-Network): the amounts that Dentegra will pay for dental services under this Policy. In-Network Benefits are those covered by this Policy and performed by a Dentegra Provider. Out-of-Network Benefits are those covered by this Policy but performed by a Non-Dentegra Provider.

Benefit Waiting Period: the period of time of continuous enrollment that an Enrollee must complete before certain dental procedures become covered benefits.

Calendar Year: the period of time beginning on January 1st and ending on December 31st.

Claim Form: the standard form used to file a claim or request a Pre-Treatment Estimate.

Deductible: a dollar amount that an Enrollee and/or the Enrollee's family (for family coverage) must pay for certain covered services before Dentegra begins paying benefits.

Dentegra PPO Provider (Dentegra Provider): a Provider who contracts with Dentegra and agrees to accept the Dentegra Contracted Fee as payment in full for services provided under a PPO plan. A Dentegra Provider also agrees to comply with Dentegra's administrative guidelines.

Dentegra PPO Provider's Contracted Fee (Dentegra Provider Contracted Fee): the fee for each Single Procedure that a Dentegra Provider has contractually agreed to accept as payment in full for treating Enrollees.

Dependent Enrollee: an Eligible Dependent enrolled to receive Benefits.

Effective Date: The date the plan starts. This date is given in your Benefits Summary.

Eligible Dependent: a dependent of the Primary Enrollee or domestic partner eligible for Benefits.

Enrollee: an individual who made application for this dental Policy ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits; may also be referred to as "Patient".

Maximum Contract Allowance: the reimbursement under the Enrollee's benefit plan against which Dentegra calculates its payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- [by a Dentegra Provider is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee; or
- by a Non-Dentegra Provider is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee for a Dentegra Provider in the same geographic area^[c1].]
- [by a Dentegra Provider is the lesser of the Submitted Fee on the claim or the Dentegra Provider's Contracted Fee; or
- by a Non-Dentegra Provider is the lesser of the Submitted Fee on the claim or the Program Allowance^[c2].]

Non-Dentegra Provider: a Provider who is not a Dentegra Provider, is not contractually bound to abide by Dentegra's administrative guidelines and has not agreed to accept the Dentegra Contracted Fees.

Patient Pays: Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Dentegra Pays" on the claims statement when a claim is processed.

Policy: this contract of insurance issued and delivered to the Enrollee. It includes the application, any attached amendments, and any appendices.

Policy Benefit Level: the percentage of Maximum Contract Allowance that Dentegra will pay after the Deductible has been satisfied.

Policy Term: the period during which the Policy is in effect.

Policy Year: the 12 months starting on the Effective Date and each subsequent 12-month period thereafter. [Deductibles and maximums will be determined using this 12-month period rather than on a Calendar Year basis^[c3].]

Premium: the amount payable by the Enrollee as provided in the Benefits Summary.

Pre-Treatment Estimate: an estimation of the allowable Benefits under this Policy for the services proposed, assuming the person is an eligible Enrollee.

Primary Enrollee: the individual insured in this plan to receive Benefits.

Procedure Code: the Current Dental Terminology (CDT)[®] number assigned to a Single Procedure by the American Dental Association.

Program Allowance: the amount determined by a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area.

Provider: a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

Single Procedure: a dental procedure that is assigned a separate CDT© number.

Submitted Fee: the amount that the Provider bills and enters on a claim for a specific procedure.

ELIGIBILITY AND ENROLLMENT

Eligibility Requirement

Primary Enrollees electing to enroll their eligible family members must enroll them at the time the Primary Enrollee enrolls or within 90 days of the Primary Enrollees initial enrollment or within 31 days of a Qualifying Status Change.

Eligible family members include:

- Your spouse or domestic partner.
- Your unmarried dependent children from birth to their 19th birthday or 25th birthday, if a full-time student in an accredited school. Proof of full-time student status must be given to us within 60 days when requested. “Children” includes natural children, step-children, adopted children, children of your domestic partner, foster children and children for which you have been appointed legal guardian. The child must be dependent on you for support. Newborn infants are eligible from the moment of birth. Adopted children are eligible from the date a petition is filed if you apply for coverage within 60 days after the filing of the petition or from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the minor.
- Your unmarried children 19 years or older may continue to be eligible as a dependent if the child is incapable of self-sustaining employment due to mental incapacity or physical handicap that began before age 19 and the child is chiefly dependent on you for support and maintenance. Proof of these facts must be given to us within 31 days if it is requested. Proof will not be required more than once a year after the child is 21.

Dependents serving active military duty are not eligible, as they are typically covered under health and dental insurance provided by the military while they are on active duty.

Qualifying Status Change is a change in:

- Legal marital status (marriage, divorce, legal separation, annulment or death); or
- Number of dependents (a child’s birth, adoption of a child, placement of a child for adoption; addition of a step or foster child or death of a child); or
- A loss of coverage under a provision dental benefits plan for reasons other than exceeding the annual or lifetime maximum benefits and provided that coverage existed for 90 continuous days without a break in coverage of more than 63 days;
or

-
- A dependent child ceases to satisfy eligibility requirements (limiting age or marital status); or
 - A court order requiring dependent coverage.

The additional Premium must be paid to us within 31 days after the date of the Qualifying Status Change in order to have the coverage continued beyond the 31 day period.

Enrollment Grace Period

There is a period of 10 days from your coverage Effective Date during which you may rescind this Policy and receive a full refund, provided you and all enrolled family members have not used any Benefits under this Policy.

[Minimum Enrollment Period

You and your covered family members selecting dental coverage must enroll for a minimum of [12] months. If coverage is voluntarily discontinued, you and your covered family members may not re-apply during the [12]-month period immediately following the voluntary termination^{[c4].}

RENEWABLE - PREMIUM MAY CHANGE CONDITIONALLY:

The Primary Enrollee may keep this Policy in force by timely payment of the premiums. However, Dentegra may refuse renewal due to:

- 1) Non-payment of premiums, subject to the “Grace Period on Late Payment” provision; or
- 2) Fraud or material misrepresentation made by or with the knowledge of the Primary Enrollee or an Eligible Dependent applying for this coverage or filing a claim for Benefits; or
- 3) The Primary Enrollee fails to comply with material provisions of this Policy; or
- 4) The company ceasing to renew all Policies issued on this form to residents of the state where you live.

At least 30 days notice of any non-renewal action permitted by this clause will be mailed to the Primary Enrollee at your last address as shown in Dentegra’s records. If Dentegra fails to provide 30 days notice of our intent to terminate coverage, your coverage will remain in effect until 30 days after notice is given or until the effective date of replacement coverage, whichever occurs first. However, no Benefits will be paid for expenses incurred during any period of time for which premium has not been paid.

Dentegra will provide 30 days advance written notice of any change in premium at renewal.

Termination of Coverage

You have the right to terminate your coverage under this Policy by sending us written notice of your intent to terminate this Policy. Termination of this Policy and coverage for you and all Enrollees under this Policy will be effective on the last day of the month that we receive your written request of termination.

A full refund of premium is available if a written request for a refund is made within the first 10 days of the Effective Date. After that, all requests for a premium refund will be prorated based upon the number of months remaining in the Policy Term, subject to the following exceptions:

- 1) A refund is not available if you or your Dependent Enrollee have received Benefits under this Policy;
- 2) There must be at least one month remaining in the Policy Term. Since coverage is based on a full calendar month, there are no partial month refunds.
- 3) Your Dependent Enrollee may disenroll from coverage under this Policy at any time. Termination of coverage for the disenrolled dependent shall occur on the last day of the month we receive written notice of the Enrollee's disenrollment. Coverage for your Dependent Enrollee will automatically terminate on the last day of the month in which the Enrollee no longer meets eligibility requirements.

We have the right to terminate this Policy and your coverage if you fail to pay your Premium or if your Premium payment is not received by us by the 31st day following the date it is due. Please see the section titled "Grace Period on Late Payments" for more information.

We also have the right to terminate your coverage:

- Upon 15 days written notice if you:
 - Are guilty of misconduct detrimental to safe operations and the delivery of services while in a Dentegra Provider's facility; or
 - Knowingly commit or permit another person to commit fraud or deception in obtaining Benefits.
- Upon 30 days written notice if you fail to pay coinsurance; provided however, that you may be reinstated during the Policy Term upon payment of all delinquent charges.

If your coverage is terminated, we will send a written notice to you informing you of the reason(s) why coverage is terminated and the date that your coverage will end. However, coverage will continue for 31 days to complete any Single Procedure begun but not completed before the Effective Date of termination.

Reinstatement

If you do not pay your premium within the time granted for payment, your Policy will be terminated. If your Policy is terminated you [may re-enroll in the program and any waiting period, deductibles and maximum applicable to your program will start again.] [must wait [12] months before re-enrolling in the program and any waiting periods, deductible and maximums applicable to your program will start again^[LK5].] However, your Policy may be reinstated with no break in coverage provided the full premium due is received by us within 60 days of the date of the past due premium. The reinstated Policy will have the same rights as before your Policy lapsed, unless a change is made to your Policy in connection with the reinstatement. These changes, if any, will be sent to you for you to attach to your Policy.

OVERVIEW OF DENTAL BENEFITS

This section provides information that will give you a better understanding of how this dental plan works and how to make it work best for you.

[Benefit Waiting Period

Some of the services in your dental plan are subject to a waiting period. Please refer to your Benefits Summary (Appendix A). No exceptions or credits are given for prior coverage. Enrollees who terminate from the dental plan and later re-apply will be required to satisfy another [12]-month waiting period during the new enrollment with no credit for prior enrollment^[c6].

Benefits, Limitations and Exclusions

We will pay the Benefits for the types of dental services as described below. We will pay Benefits only for covered services. The services provided through this Policy are described in the Benefits Summary. This Policy covers several categories of benefits when a Provider furnishes the services and when they are necessary and within the standards of generally accepted dental practice. Claims shall be processed in accordance with our standard processing policies. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Policy. Even if the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

Enrollee Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services, as shown in the Benefits Summary, subject to certain limitations, and you are responsible for paying the balance. What you pay is called the enrollee coinsurance (“Enrollee Coinsurance”) and is part of your out-of-pocket cost. You pay this even after a Deductible has been met.

The amount of your Enrollee Coinsurance will depend on the type of service and the Provider furnishing the service (see section titled “Selecting Your Provider”). Providers are required to collect Enrollee Coinsurance for covered services. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to you, we will be obligated to provide as Benefits only the applicable percentages of the Provider’s fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

It is to your advantage to select Dentegra Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to the sections titled “Selecting Your Provider” and “How Claims Are Paid” for more information.

Deductible

Your dental plan features a Deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The Deductible amounts are listed in the Benefits Summary. Deductibles apply to all benefits unless otherwise noted. Only the Provider’s fees you pay for covered Benefits will count toward the Deductible.

Maximum Amount

Your dental program has a maximum dollar amount we will pay toward the cost of dental care (“Maximum Amount”). You are responsible for paying costs above this amount. The Maximum Amount payable is shown in the Benefits Summary. Maximums may apply on a yearly basis, a per services basis, or a lifetime basis.

Benefits

To help you understand the types of procedures that are included in each category, the following is a description of each of the categories of services that are covered under this Policy.

We will pay the Policy Benefit Level shown in the Benefits Summary for the following services:

Diagnostic and Preventive Benefits:

- Diagnostic: procedures to assist the Provider in choosing required dental treatment.
- Preventive: cleaning [(periodontal cleaning in the presence of inflamed gums is considered to be a Basic Benefit for payment purposes)], topical application of fluoride solutions, and space maintainers.
- [Sealants: topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay^[c7].]

[Basic Benefits:

- [Oral Surgery: extractions and other surgical procedures (including pre- and post-operative care^[c8]).
- General Anesthesia or IV Sedation: when administered by a Provider for oral surgery or selected endodontic and periodontal surgical procedures.
- Anesthesia and hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a hospital or ambulatory surgical facility if the Provider certifies that, because of the Enrollee's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the patient is:
 - 1) a child under seven (7) years of age who is determined by two (2) licensed dentists to require, without delay, necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; or
 - 2) a person with a diagnosed serious mental or physical condition; or
 - 3) a person with a significant behavioral problem as determined by your licensed Provider.
- [Endodontics: treatment of diseases and injuries of the tooth pulp^[c9].]
- [Periodontics: treatment of gums and bones supporting teeth^[c10].]

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- [Palliative: treatment to relieve [pain](#)^[LK11].]
 - [Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing [decay](#)^[c12].]
 - [Restorative: amalgam, synthetic porcelain, plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of [decay](#)^[c13]).]
 - [Denture Repairs: repair to partial or complete dentures including rebase procedures and [relining](#)^[c14].]

[Major Benefits:

- [Oral Surgery: extractions and other surgical procedures (including pre- and post-operative [care](#)^[c15]).]
- [Endodontics: treatment of diseases and injuries of the tooth [pulp](#)^[c16].]
- [Orthodontic: procedures performed by a Provider using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their [function](#)^[LK17]]
- [Periodontics: treatment of gums and bones supporting [teeth](#)^[c18].]
- [Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain or plastic [restorations](#)^[c19].]
- [Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; [implant surgical placement and removal; and for implant supported prosthetics, including implant repair and [recementation](#)^[c20].]
- [Implants: procedures performed by a Provider for endodontic endosseous, endosteal, eposteal and transosteal implants; implant connecting bars and implant repairs. Implants are defined as prosthetic applicances placed into or on the bone of the maxilla or mandible (upper or lower jaw) to retain or support dental [prosthesis](#)^[LK21]]
- [Dental Accident: An injury to the mouth or structures within the oral cavity which is caused by an external traumatic force. It does not include damage to the teeth which is the result of biting into food or other substances. Procedures shall include but are not limited to reimplantation, splinting and [stayplate](#)^[LK22].]

Note on additional Benefits during pregnancy: When an Enrollee is pregnant, we will pay for additional services during the pregnancy. The additional services each [12 month^{c23} period] [Policy Year] while the Enrollee is covered under this Policy include: one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

Limitations and Exclusions

Dental plans are designed to help with part of your dental expenses and may not always cover every dental need. The typical program includes Limitations and Exclusions, meaning the program does not cover every aspect of dental care. This can relate to the type of procedures or the number of visits. Please read the following sections to help you understand the Limitations and Exclusions of this dental plan.

Limitations

Benefits to Enrollees are limited as follows:

Limitations on Diagnostic and Preventive Benefits:

- We will pay for routine oral examinations (including any office visits for observation and specialist consultations, or combination thereof), cleanings (including periodontal cleanings or any combination thereof) and topical application of fluoride solutions no more than [twice^{LK24}] in any 12 month period. Note that periodontal cleanings are covered as a [Basic Benefit] and^{c25} routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional benefits during pregnancy.
- Specialist consultations are only a Benefit when an opinion or advice is requested by a general dentist and the treatment is not performed by the specialist.
- X-ray limitations:
 - a) Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
 - b) When a panoramic film is submitted with supplemental film(s), Dentegra will limit the total reimbursable amount to the Accepted Fee for a complete intraoral series.

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- c) If a panoramic film is taken in conjunction with an intraoral complete series, Dentegra considers the panoramic film to be included in the complete series.
 - d) A complete intraoral series and panoramic films by the same Provider/Provider office are limited to once each every [five (5)] years_[c26].
 - e) Bitewing x-rays are limited to [two (2) times in any 12 month period] when provided to Enrollees under 18 and [one (1) time each 12 months] for Enrollees age 18 and over. Bitewings are not a Benefit within six (6) months of an intraoral complete series unless warranted by special circumstances such as active periodontal disease or rampant caries_[c27].
 - [Topical application of fluoride solutions is limited to Enrollees to age 19_[c28].]
 - Space maintainers are limited to the initial appliance and are a benefit for an Enrollee under age [14_[c29]]. For Enrollees ages 14 and 15, an allowance for a space maintainer will be considered until a fixed bridges or removable partial dentures can be placed.
 - Cephalometric x-rays, oral/facial photographic images (once per case) and diagnostic casts (once per case) are benefits only in conjunction with orthodontic services and only when orthodontic services are a covered Benefit.
 - [Sealants are limited as follows_[c30]:
 - a) to permanent first molars through age [eight (8)] and to permanent second molars through age [15] if they are without caries (decay) or restorations on the occlusal surface.
 - b) do not include repair or replacement of a sealant on any tooth within [two (2)] years of its application_[c31].]

Limitations on Basic Benefits:

- [Sealants are limited as follows_[c32]:
 - a) to permanent first molars through age [eight (8)] and to permanent second molars through age [15] if they are without caries (decay) or restorations on the occlusal surface.
 - b) do not include repair or replacement of a sealant on any tooth within [two (2)] years of its application_[c33].]
- We will not pay to replace an amalgam, synthetic porcelain or plastic restorations (fillings) or prefabricated resin and stainless steel crowns within [24 months_[c34]] of treatment if the service is provided by the same Provider.

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- We limit payment for prefabricated resin and stainless steel crowns under this section to services on baby (deciduous) teeth. However, after a consultant's review, we may allow stainless steel crowns on permanent teeth as a [Major Benefit^[c35].]
 - [Retreatment of root canal therapy within 24 months of the initial procedure is not a Benefit when performed by the same Provider^[c36].]
 - [Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing.] See note on additional Benefits during pregnancy^[c37].
 - Extractions and oral surgery procedures performed for Orthodontic treatment are not a Benefit except as provided under Orthodontic Benefits, if applicable.

Limitations on Major Benefits:

- Crowns, inlays/onlays and cast restorations are covered no more often than once in any [five (5) year period] except when we determine the existing crown, or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues^[c38].
- Prosthodontic appliances and/or implants that were provided under any Dentegra program will be replaced only after [five (5) years^[c39]] have passed, except when we determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Dentegra program will be made if we determine it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Dentegra's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Dentegra or any other dental care plan.
- When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.
- Recementation of crowns, inlays/onlays or bridges is not a Benefit when performed by the same Provider within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation.
- [The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is

made necessary by natural, permanent teeth extraction occurring during a time you were eligible under a Dentegra [program][c40].]

- We limit payment for dentures to a standard partial or denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care and rebase (including relining and any adjustments) for the first six (6) months after placement. Additional Denture benefit limitations are:
 - a) Denture rebase is limited to one (1) per arch in a 24 month period.
 - b) Denture relines and tissue conditioning are limited to two (2) per arch in a 12 month period. Tissue conditioning provided on the same day a denture is delivered or a reline or rebase has been performed is not a Benefit.
- The Orthodontic Benefit maximum amount payable for each Enrollee during the Enrollee's [lifetime][Policy Year][LK41] is shown in the Benefits Summary. Additional Orthodontic benefit limitations are:
 - a) Orthodontic Benefits will be provided in two (2) payments after the person becomes covered, (one initial payment and the second in twelve (12) months), except for treatment plans of less than \$500 which will be paid in one (1) [payment][c42].
 - b) Orthodontic Benefits are not paid to repair or replace any orthodontic appliance received under this program.
 - c) Non-Orthodontic procedures performed for the purpose of Orthodontic treatment are subject to the Orthodontic Benefit and maximum if covered as Benefits under Dentegra's standard processing policies.
 - d) Orthodontic Benefits are limited to dependent child Enrollees under the age of 19[c43].]
- Implant Benefits are subject to all the Limitations, Exclusions and other terms and conditions in this Policy. Additional implant benefit limitations are:
 - a) Diagnostic and treatment facilitating aids are considered a part of, and included in, the fees for the definitive treatment.
 - b) Bone graphs provided for implants on the same day as service.
- Dental Accident Benefits are subject to all the Limitations, Exclusions and other terms and conditions in this Policy. Additional Dental Accident benefit limitations are:
 - a) The dental accident must occur while you are covered under this Policy.

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- b) Services and procedures must be provided within 180 days following the dental accident and while you are covered under this Policy.

Limitations on All Benefits - Optional Services:

Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called “Optional Services”. Optional Services also include the use of specialized techniques instead of standard procedures. For example:

- A Crown where a filling would restore the tooth; or
- a precision denture/partial where a standard denture/partial could be used; or
- an Inlay/Onlay instead of an amalgam restoration; or
- porcelain, resin or similar materials for Crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a full metal crown) [; or/.]
- [a composite restoration instead of an amalgam restoration on posterior teeth^[c44].]

If you receive Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. You will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

Exclusions

This Policy covers a wide variety of dental care expenses, but there are some services for which we do not provide benefits. It is important for you to know what these services are before you visit your Provider.

We do not pay benefits for:

- Treatment of injuries or illness covered by workers’ compensation or employers’ liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- Cosmetic surgery or procedures for purely cosmetic reasons.
- Maxillofacial prosthetics.
- Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those

services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.

- Treatment to restore tooth structure lost from wear, erosion, or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize teeth. Examples include but are not limited to: equilibration, periodontal splinting, occlusal adjustments or occlusal guards.
- Single surface restorations placed on the same surface as a sealant and within 12 months of the initial sealant application or multiple surface restorations placed on the same surface as a sealant and within six (6) months of the initial sealant application.
- Any Single Procedure started prior to the date the Enrollee became covered under this plan.
- Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental procedures.
- Charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed Provider in connection with oral surgery or selected endodontic and periodontal surgical procedures, except as allowed under Basic Benefits.
- Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- Porcelain and porcelain fused to metal crowns for Enrollees under age 12.
- Fixed bridges and removable partials for Enrollees under age 16.
- Interim implants.
- Resin-based inlays and onlays.
- Overdentures.
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- Treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments.
- Dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary

materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

- Services or supplies covered by any other health plan.
- Treatment rendered by a person who ordinarily resides in your household or who is related to you (or to your spouse) by blood, marriage or legal adoption.
- Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- [The initial placement of any prosthodontic appliance or implants unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under this Policy or was covered under any dental care program with Dentegra. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth[D45].]
- Services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Major Benefit section, if applicable.
- Procedures performed for the purpose of orthodontic treatment are not a Benefit except as provided under Major Benefits, if applicable.
- Services for any disturbance of the temporomandibular (jaw) joints or associated musculature, nerves and other tissues (TMJ).
- [Services or supplies for oral surgery, general anesthesia, palliative treatment, or sealants[D46].]
- [Services or supplies for endodontic treatment[D47] (procedures for removal of the nerve of the tooth and the treatment of the pulp cavity portion of the root of the tooth).]
- [Services or supplies for periodontic treatment (procedures for the treatment of the gums and the bones supporting teeth[D48]).]
- [Services or supplies for restorative treatment (amalgam, synthetic porcelain, plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).][D49]
- [Services or supplies for denture repairs (repair to partial or complete dentures including rebase procedures and relining.)][D50]
- [Services or supplies for crowns, cast restorations, inlays/onlays for treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain, plastic restorations.][D51]

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- [Services or supplies for prosthodontic benefits (procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges.)][D52]
 - [Services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures][LK53].]

Pre-Treatment Estimates

Pre-treatment estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. We will estimate the amount of Benefits payable under this Policy for the listed services. By asking your Provider for a Pre-Treatment Estimate from us before you agree to receive any prescribed treatment, you will have an estimate up front of what we will pay and the difference you will need to pay. The Benefits will be processed according to the terms of this Policy when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days, or until an earlier occurrence of any one of the following events:

- 1) the date this Policy terminates;
- 2) the date the Dependent Enrollee's coverage ends; or
- 3) the date the Provider's agreement with Dentegra ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if you are covered and meet all the requirements of the plan at the time the treatment you have planned is completed and may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

SELECTING YOUR PROVIDER

Free Choice of Provider

We recognize that many factors affect the choice of Provider and therefore support your right to freedom of choice regarding your Provider. This assures that you have full access to the dental treatment you need from the dental office of your choice. You may see any Provider for your covered treatment, whether the Provider is a Dentegra Provider or a Non-Dentegra Provider. In addition, you and your family members can see different Providers.

Remember, you enjoy the greatest benefits—including out-of-pocket savings—when you choose a Dentegra Provider. To take full advantage of your benefits, we highly recommend you verify a dentist's participation status within a Dentegra network with your dental office before each appointment. Review the section titled "How Claims

Are Paid” for an explanation of Dentegra payment procedures to understand the method of payments applicable to your Provider selection and how that may impact your out-of-pocket costs.

Locating a Dentegra Provider

You may access information through our web site at www.dentegra.com. You may also call our Customer Service Center and one of our representatives will assist you. We can provide you with information regarding a Provider’s network, specialty and office location.

HOW CLAIMS ARE PAID

Payment for Services — Dentegra Provider

Payment for covered services performed for you by a Dentegra Provider is calculated based on the Maximum Contract Allowance, which is the lesser of the submitted fee on the claim or the Dentegra Provider’s Contracted Fee. Dentegra Providers have agreed to accept the Dentegra Provider’s Contracted Fee as the full charge for covered services.

The portion of the Maximum Contract Allowance payable by us is limited to the applicable Policy Benefit Level shown in the Benefits Summary. Dentegra’s payment is sent directly to the Dentegra Provider who submitted the claim. We advise you of any charges not payable by us for which you are responsible. These charges are generally your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

Payment for Services — Non-Dentegra Provider

Payment for services performed for you by a Non-Dentegra Provider is also calculated based on the Maximum Contract Allowance. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Policy Benefit Level shown in the Benefits Summary.

However, when dental services are received from a Non-Dentegra Provider, Dentegra’s Payment is sent directly to the Primary Enrollee. You are responsible for payment of the Non-Dentegra Provider’s Submitted Fee. Non-Dentegra Providers will bill you for their normal charges, which may be higher than the Maximum Contract Allowance for the service. You may be required to pay the Provider yourself and then submit a claim to us for reimbursement. Since our payment for services you receive may be less than the Non-Dentegra Provider’s actual charges, your out-of-pocket cost may be significantly higher.

How to Submit a Claim

Claims for Benefits must be filed on a standard Claim Form, which most dental offices have available. Dentegra Providers will fill out and submit your claims paperwork for you. Some Non-Dentegra Providers may also provide this service upon your request. If you receive services from a Non-Dentegra Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled “Claim Form” for more information.

Your dental office should be able to assist you in filling out the claim form. Fill out the claim form completely and send it to:

Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Payment Guidelines

We do not pay Dentegra Providers any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If you or your Provider files a claim for services more than 12 months after the date you received the services, payment may be denied. If the services were received from a Non-Dentegra Provider, you are still responsible for the full cost. If the payment is denied because your Dentegra Provider failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your Dentegra Provider that you were covered under a Dentegra Policy at the time you received the service, you may be responsible for the cost of that service.

We explain to all Dentegra Providers how we determine or deny payment for services. We describe in detail the dental procedures covered as benefits, the conditions under which coverage is provided and the plan’s limitations and exclusions. If any services are not covered, or if limitations or exclusions apply to services you have received, you may be responsible for the full payment.

If you have any questions about any dental charges, processing policies and/or how your claim is paid, please contact us.

PREMIUM PAYMENT RESPONSIBILITIES

The Primary Enrollee is responsible for making premium payments, paying Deductibles and Enrollee Coinsurance and ensuring your Provider is aware of any other dental coverage you carry. These are explained in detail in the following subsections.

[Rate Guarantee

For plans with waiting periods, your initial premium rate is guaranteed for the first two years of continuous coverage under your Policy, based upon the new enrollee rates in force at the time you apply for coverage. After the first two years, premium rates may be adjusted annually. If you move, or change your enrollment options, your premium rate may also **change**^[c54].

Premium Billing

When you completed your application, you selected your dental benefits and the method for paying your ongoing premiums, either by check or through Electronic Funds Transfer (EFT). The following is a description of how each of these methods works.

Pay by Check

If you selected to pay by check, you also selected the option of paying your premiums quarterly, semi-annually or annually.

If you elected to pay your premiums quarterly, semi-annually, or annually, you will receive an invoice once every billing period.

Your payment must be received by the 20th of the month in which it is due to ensure coverage for the following billing period. All payments are to be mailed to the following address:

Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Pay by Electronic Funds Transfer (EFT)

If you chose to pay your premium on a monthly basis through monthly EFT, Dentegra will transfer the premium payment from your bank account at the end of each month for the following month's coverage.

If funds aren't available, your account will be considered delinquent.

If the account continues to be delinquent for more than 31 days, your Policy will be terminated.

Changing Payment Options

Payment options may be changed at any time; however, the effective date of the change varies dependent on your payment option. Changes to EFT, quarterly and semi-annual

payment options are effective on the anniversary or semi-anniversary of your Policy Effective Date. Changes to the annual payment option are effective on the anniversary of your Policy Effective Date. To change your payment option you can call our Customer Service Center toll-free at 877-280-4204 during regular business hours or write to the Customer Service Center at:

Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023

Grace Period on Late Payments

If your premium payment is not received by the first of the month a grace period of 31 days will be granted. During the grace period the Policy shall continue in force.

If the account continues to be delinquent for more than 31 days, your Policy will be terminated.

COMPLAINTS AND APPEALS

Our commitment to you is to ensure quality throughout the entire dental benefit process: from the courtesy extended to you by our Customer Service representatives to the dental services provided by Dentegra Providers. If you have questions about any services received, we recommend that you first discuss the matter with your Provider. However, if you continue to have concerns, please call our Customer Service Center. You can also e-mail questions by accessing the “Contact Us” section of our web site at www.dentegra.com.

Complaints regarding eligibility, the denial of dental services or claims, the policies, procedures, or operations of Dentegra, or the quality of dental services performed by the Provider may be directed in writing to us or by calling us toll-free at 877-280-4204.

When you write, please include the name of the Enrollee, the Primary Enrollee’s name and ID number, and your telephone number on all correspondence. You should also include a copy of the claim form, claim statement, or other relevant information. Your claim statement will have an explanation of the claim review and any complaint process and time limits applicable to such process.

We will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. You and your Provider have at least 180 days after receiving a notice of denial to request a review by writing to Dentegra giving reasons why you believe the denial was wrong. You may also ask

Dentegra to examine any additional information you include that may support your complaint.

Send your complaint to us at the address shown below:

Dentegra Insurance Company

P.O. Box 1809

Alpharetta, GA 30023

We will send you a written acknowledgment within 5 days upon receipt of your complaint. We will make a full and fair review within 30 days after we receive the complaint. We may ask for more documents if needed. We will send you a decision within 30 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of this Policy, we shall consult with a dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual.

Appeals

If you believe you need further review of your claim and/or your complaint, you may contact your state insurance regulatory agency.

PROVISIONS REQUIRED BY LAW

Entire Contract; Changes

This Policy, including the endorsements and the attached papers, constitutes the entire contract of insurance. No change to this Policy shall be valid until approved by our executive officer and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

Incontestability

After 3 years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by you in the application for this Policy will be used to void the Policy or to deny a claim for loss incurred or disability commencing after the expiration of such 3-year period.

No claim for loss incurred or disability commencing after 3 years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical

condition not excluded from coverage by name or specific description effective on the date of loss has existed prior to the effective date of this Policy.

Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, you as may be required to administer the claim, or have you be examined by a dental consultant retained by us, at our own expense, in or near your community or residence. We will in every case hold such information and records confidential.

Written Notice of Claim/Proof of Loss

We must be given written proof of loss within 12 months after the date of the loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give written proof in the time required, provided that the proof is filed as soon as reasonably possible. A notice of claim submitted by you, on your behalf, or on behalf of your beneficiary to us or to our authorized agent, with information sufficient to identify you will be considered notice of claim.

All written proof of loss must be given to us within 12 months of the termination of this Policy.

Send your Notice of Claim/Proof of Loss to us at the address shown below:

Dentegra Insurance Company

P.O. Box 1809

Alpharetta, GA 30023

Claim Form

We will, within 15 days after receiving a notice of a claim, provide you or your Provider with a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If we do not send you or your provider a claim form within 15 days after you or your Provider gave us notice regarding a claim, the requirements for proof of loss outlined in the section "Written Notice of Claim/Proof of Loss" above will be deemed to have been complied with as long as you give us written proof that explains the type and the

extent of the loss that you are making a claim for within the time established for filing proofs of loss. You may download a Claim form from our web site.

Time of Payment

Claims payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of loss . We will notify you and your Provider of any additional information needed to process the claim.

To Whom Benefits Are Paid

It is not required that the service be provided by a specific Provider. Payment for services provided by a Dentegra Provider will be made directly to the Provider. Any other payments provided by this Policy will be made to you. All benefits not paid to the Provider will be payable to you, the Primary Enrollee or Dependent Enrollee, or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, benefits may be payable to his or her parent, guardian or other person actually supporting him or her.

Misstatements on Application; Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under this Policy, all statements made by you will be deemed representations and not warranties. No such statement will be used in defense to a claim under this Policy, unless it is contained in a written application.

Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to us, we would not in good faith have issued this Policy at the same premium rate. If any misstatement would materially affect the rates, we reserve the right to adjust the premium to reflect your actual circumstances at time of application.

Legal Actions

No action at law or in equity will be brought to recover on this Policy prior to expiration of 60 days after written proof of loss has been filed in accordance with requirements of this Policy, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which written proof of loss is required by this Policy.

Conformity With State Laws

All legal questions about this Policy will be governed by the state of Arkansas where this Policy was entered into and is to be performed. Any part of this Policy which, on

its Effective Date, conflicts with the laws of Arkansas is hereby amended to conform to the minimum requirements of such laws.

NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION

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

This notice is required by law to tell you how Dentegra Insurance Company ("Dentegra") protects the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's healthcare history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Dentegra receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to our administration of your benefits. However, we may change this notice and make the new notice effective for all of your PHI that we maintain. If we make any substantive changes to our privacy practices, we will promptly change this notice and redistribute to you within 60 days of the change to our practices. You may also request a copy of this notice anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Dentegra program, and we will notify you of how you can receive a copy of this notice every three years.

Permitted Uses and Disclosures of Your PHI

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or that sponsor for purposes of administering your benefits. We may disclose PHI to third parties that perform services for Dentegra in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Dentegra in the administration of your benefits. These affiliates have implemented privacy policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

Examples of Uses and Disclosures of Your PHI for Treatment, Payment or Healthcare Operations

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Additional examples include the following.

- Uses and/or disclosures of PHI in facilitating treatment.

For example, Dentegra may use or disclose your PHI to determine eligibility for services requested by your provider.

- Uses and/or disclosures of PHI for payment.

For example, Dentegra may use and disclose your PHI to bill you or your plan sponsor.

- Uses and/or disclosures of PHI for healthcare operations.

For example, Dentegra may use and disclose your PHI to review the quality of care provided by our network of providers.

Disclosures Without an Authorization

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human

Services to investigate or determine our compliance with law, and when otherwise required by law. Dentegra may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

Disclosures Dentegra Makes With Your Authorization

Dentegra will not use or disclose your PHI without your prior authorization if the law requires your authorization. You can later revoke that authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by Dentegra or by a person requesting your PHI from Dentegra.

Your Rights Regarding PHI

You have the right to request an inspection of and obtain a copy of your PHI. You may access your PHI by contacting the appropriate Dentegra office. You must include (1) your name, address, telephone number and identification number and (2) the PHI you are requesting. Dentegra may charge a reasonable fee for providing you copies of your PHI. Dentegra will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or X-rays, is returned by Dentegra to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Dentegra does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact the privacy office as noted below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

You have the right to correct or update your PHI. This means that you may request an amendment of PHI about you for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

You have the right to request or receive confidential communications from us by alternative means or at a different address. We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, another method of contact or information as to how payment will be handled. Please make this request in writing to the privacy office as noted below.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to April 14, 2003. Please contact the privacy office as noted below if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by e-mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

Complaints

You may complain to us or to the U. S. Secretary of Health and Human Services if you believe that Dentegra has violated your privacy rights. You may file a complaint with us by notifying the privacy office as noted below. We will not retaliate against you for filing a complaint.

Contact

You may contact the privacy office at the address and telephone number listed below for further information about the complaint process or any of the information contained in this notice.

Address: Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Phone: 877-280-4204

This notice is effective on and after July 1, 2006.

APPENDIX A

Benefits Summary

Coinsurance Plan

The services provided through this Policy include all the benefits described in this Benefit Summary, with the exception of those items listed in the Limitations and Exclusions, subject to our processing policies. The percentages listed are based upon the share of the Dentegra Maximum Contract Allowance paid by Dentegra (Policy Benefit Level) and the patient (Enrollee Coinsurance). The patient's share may be higher depending on the applicability of Deductibles, maximums, the difference between a Non-Dentegra Provider's fee and the Maximum Contract Allowance or the Dentegra Provider Contracted Fee or charges for non-covered services.

Primary Enrollee: [Name]

Effective Date: [XXXXX]

Plan:

You have a [Policy Year][Calendar Year] plan and deductibles and maximums will be based upon a [Policy Year][Calendar Year]. [Policy Year is the 12 months starting on the Effective Date and each subsequent 12 month period thereafter] [Calendar Year is the period of time beginning on January 1st and ending on December 31st and each subsequent 12 month period thereafter[LK55]].

Benefits:

Policy Benefit Level

Diagnostic and Preventive Benefits:	[50 – 100[LK56]]%
Basic Benefits:	[50 – 90[LK57]]%
Major Benefits:	[40 – 50[LK58]]%
[Orthodontic Benefits[LK59]]	50%

Percentages are based on the Maximum Contract Allowance.

[Standard Incentive Plan[c60]:

Dentegra shall pay or otherwise discharge the following Policy Benefit Level of the Maximum Contract Allowance for the following services:

Plan [XX]	Paid by Dentegra during the First Year	Paid by Dentegra during the Second Year	Paid by Dentegra during the Third Year	Paid by Dentegra during the Fourth Year and thereafter
Diagnostic & Preventive Benefits[LK61]	XX%	XX%	XX%	XX%
Basic Benefits[LK62]	XX%	XX%	XX%	XX%
Major Benefits[LK63]	XX%	XX%	XX%	XX%
[Orthodontic Benefits[LK64]	XX%	XX%	XX%	XX%

Benefits will increase each year, on the anniversary of the Primary Enrollee's Effective Date, if the Enrollee utilizes the Benefits of the plan. If the plan is not utilized the benefit level will [remain at the attained level] [drop to the next lowest level] [drop to the base level]. Under no circumstances will the benefit level fall below the base benefit level. [Benefits for Enrollees with a break-in-coverage will decrease to the base level[LK65].]

[Enrollee Incentive Plan[c66]:

Dentegra shall pay or otherwise discharge the following Policy Benefit Level of the Maximum Contract Allowance for the following services:

Plan [XX]	Paid by Dentegra during the First Year	Paid by Dentegra during the Second Year	Paid by Dentegra during the Third Year	Paid by Dentegra during the Fourth year and thereafter
Diagnostic & Preventive Benefits[LK67]	XX%	XX%	XX%	XX%
Basic Benefits[LK68]	XX%	XX%	XX%	XX%
Major Benefits[LK69]	XX%	XX%	XX%	XX%
[Orthodontic Benefits[LK70]	XX%	XX%	XX%	XX%

Benefits will increase on the anniversary of the Primary Enrollee's Effective Date under this Policy. [Benefits for Enrollees with a break-in-coverage will decrease to the base level[LK71].]

Waiting Periods:[D72]

- [[Basic Benefits [d73]are limited to Enrollees who have been covered under this Policy for [12[d74]] consecutive months.] [Waiting periods are calculated for each

Primary Enrollee and/or Dependent Enrollee from the Effective Date for the Primary Enrollee and/or Dependent Enrollee.]]

[[Basic Benefits [d75]are limited to Enrollees who have been covered under this Policy for [12[d76]] consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee’s length of coverage.]]

- [[Major Benefits [d77]are limited to Enrollees who have been covered under this Policy for [12[d78]] consecutive months.] [Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date for the Primary Enrollee and/or Dependent Enrollee.]]

[[Major Benefits [d79]are limited to Enrollees who have been covered under this Policy for [12[d80]] consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee’s length of coverage.]]

- [[Orthodontic Benefits [d81]are limited to [Dependent Children of Primary Enrollees[d82]] [Primary Enrollees and their Dependents[d83]] who have been covered under this Policy for [12[d84]] consecutive months.] [Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective for the Primary Enrollee and/or Dependent Enrollee.]]

[[Orthodontic Benefits [d85]are limited to [Dependent Children of Primary Enrollees[d86]] [Primary Enrollees and their Dependents[d87]] who have been covered under this Policy for [12] [d88]consecutive months. The waiting period for a Dependent Enrollee is determined by the Primary Enrollee’s length of coverage.] [Waiting periods are calculated for each Primary Enrollee from the Effective Date for the Primary Enrollee.]]

Deductible Amount:

For each Enrollee per [Calendar Year] [Policy Year]: \$.[D89]

For each family per [Calendar Year] [Policy Year]: \$.[D90]

[The Deductible does not apply to Diagnostic and Preventive Services[d91].]

Maximum Amount:

- \$[xxx][LK92] per Enrollee per [Policy Year] [Calendar Year][LK93].
- [\$xxx][LK94] per [[Enrollee/dependent child Enrollee] per [lifetime][d95]/Policy Year] for Orthodontic Benefits.]

[The Maximum Amount does not apply to Diagnostic and Preventive Services[D96].]

Premiums:

[Per Primary Enrollee: \$ XXXX
Per Primary Enrollee with one Dependent: \$ XXXX
Per Primary Enrollee with two or more Dependents \$ XXXX[LK97]

Premiums are to be remitted to:

Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not limited, however. And, as noted in the box below, this protection is not a substitute for consumers’ care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”) may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state.

You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract. Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association

c/o The Liquidation Division

1023 West Capitol

Little Rock, Arkansas 72201

Arkansas Insurance Department

1200 West Third Street

Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act (“Act”). Below is a brief summary of the Act’s coverage’s, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone’s rights or obligations under the Act or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The

beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the law of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured's who live outside that state).
- The insurer was not authorized to do business in this state.
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to groups contract holders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plan protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an allocated annuity contract now owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;

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- Obligation that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
 - Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNTS OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 –no matter how many policies and contracts there were with the same company, even if they provided different types of coverage's. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage's. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.