COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200, COLUMBIA, SC 29223-5666
P.O. BOX 100102, COLUMBIA, SC 29202-31 02
(803) 735-1251
the "Company")

Policy No.: TSE371 1

Effective Date:

Policyholder:

Date of Policy Issue: January 1, 2017

Policy delivered in Illinois and subject to the laws of that jurisdiction.

Policy Renewal Dates: Policy Anniversary date and the same date of each year thereafter.

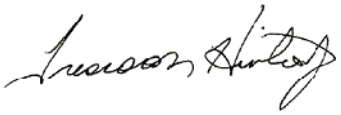
In consideration of the Application made by the Policyholder, and receipt of any and all Premiums when due, Companion Life Insurance Company agrees to provide the coverage described herein subject to all provisions of the Policy and any amendments added to the Policy.

The first premium is due on the date of issue of the Policy. The Policy shall renew each Policy Renewal Date unless Terminated in accordance with the Policy Termination provision. The Entire Contract provision of the policy determines all rights and Benefits of persons who are insured hereunder.

This page and the pages which follow are all part of the Policy and is fully recited over the signatures shown below.

In witness whereto, Companion Life Insurance Company has caused the Policy to be signed and issued as of January 1, 2017, and shall take effect on the Policy Effective Date specified above.

"READ YOUR CERTIFICATE CAREFULLY!"



Trescott N. Hinton, Jr.
President

GROUP DENTAL INSURANCE CERTIFICATE
RENEWAL AT OPTION OF THE COMPANY

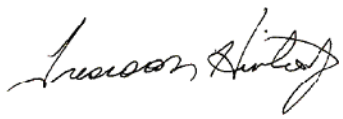
The Insurance Company certifies that the person named above is insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

The group policy may be amended or cancelled without the consent of the Insured Person.

This certificate replaces all certificates previously issued to the Insured Person under Said policy.

The group policy and this certificate are governed by the laws of the state in which the Group policy was delivered.

ANY DENTAL CARE INSURANCE BENEFITS PAYABLE UNDER THE POLICY DESCRIBED HEREIN MAY BE COMBINED WITH THE BENEFITS PAYABLE UNDER OTHER PLANS OR PROGRAMS SO THAT THE TOTAL REIMBURSEMENT FOR ALLOWABLE EXPENSES DOES NOT EXCEED THE ACTUAL EXPENSES INCURRED.



Trescott N. Hinton, Jr.
President

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SCHEDULE OF BENEFITS

Dental by Design

Group Name: **Group Policy Number:** ---

Class of Employees Eligible for Insurance	All Active Employees
Persons Covered	Employee and Dependent
Employment Waiting Period	
Predetermination of Benefits Amount Applicable to All Classes of Service	$200.00
Maximum Contract Year Payment Applicable to Each Insured Person for Covered Services Other Than Orthodontia	$750
Annual Deductible Amount Applicable to Each Insured Person for Covered Services Other Than Orthodontia	$50
Deductible Waived for Class I Services	Yes
Waiting Period for Class II Services	0 Months
Waiting Period for Class III Services	12 Months
Orthodontic Services	No
Lifetime Deductible Amount Applicable To Each Dependent Child for Orthodontic Services	N/A
Lifetime Maximum Applicable To Each Dependent Child for Orthodontic Services	N/A
Waiting Period for Orthodontic Services	N/A
Prior Insurance Credit	Yes

Percentage of Covered Dental Expenses Payable:

Covered Charges in excess of the Lifetime Deductible Amount will be paid by Companion Life up to the Maximum Annual Payment or Orthodontia Lifetime Maximum Payment (if applicable) at the Coinsurance Rates shown below:

Class I	Preventive Services	100%
Class II	Basic Services	80%
Class III	Major Services	50%
Class IV	Orthodontic Services	N/A

Standard Takeover – An employee's (and dependent's, if applicable) waiting periods will be reduced by the amount of time the employee (and dependent, if applicable) was insured under the employer's prior plan for similar benefits. The current dental plan must have been in force continuously for at least 12 months prior to the effective date of this plan and the employee must have been insured by the prior plan on its date of termination. Takeover applies to Class II (Basic), Class III (Major), and Class IV (Ortho) procedures.

ELIGIBILITY

Personal Insurance

All Employees who work for the Company for at least 30 hours per week on a regular basis and are on the regular payroll of the Company for that work.

If a husband and wife are both Employees, and if either of them insure their dependent children, then either the husband or wife, whomever so elects, will be considered a dependent of the other. As a dependent, the person will not be an Employee eligible for insurance as an employee, but will be eligible for insurance as a dependent.

Dependent Insurance

All Employees who work for the Company for at least 30 hours per week on a regular basis and are on the regular payroll of the Company for that work.

Either spouse who elects to be a dependent rather than an Employee of the Eligible Class for Personal Insurance, as explained above, is not an Employee of the Eligible Class for Dependent Insurance.

WAITING PERIOD

Employees who become employed by an Employer will qualify for Insurance after completing a waiting period of one, two or three calendar months of continuous active service. The length of the waiting period is selected by each Employer and must be the same for each employee.

PARTICIPATION

For Insurance on the Employees of an Employer to be placed in force and to remain in force, a minimum number of 10 Employees must be participating at all times.

Personal Insurance

For Insurance on the Employees of an Employer to be placed in force and to remain in force, a certain percentage of Employees in each Group must be insured at all times.

Percentage of Employees Eligible for Personal Insurance:

	Percentage
Employers with ten or more eligible employees	50%

Dependent Insurance

Percentage of Employees Eligible for Dependent Insurance:	Percentage
Employers with ten or more eligible employees	50%

CONTRIBUTIONS

Personal Insurance

An Insured may or may not be required to contribute to the payment of his or her Insurance premiums. Each Employer will make this decision. This decision must be applied equally to all Insureds.

Dependent Insurance

An Insured may or may not be required to contribute to the payment of Insurance premiums for his or her dependents. Each Employer will make this decision. This decision must be applied equally to all Insureds.

CONTINUATION OF COVERAGE

An Insured or dependent whose insurance has stopped may be able to continue some or all of the insurance coverages. The sections following explain when and how insurance can be continued. If insurance is continued, it must be according to a plan which does not allow individual selection.

Federally Required Continuation

Through the Consolidated Omnibus Budget Reconciliation Act (COBRA) the Federal government requires the Employer to provide continuation of coverages to Insureds and/or dependents who would otherwise lose their coverage. There are some groups which are not subject to the law. They are:

1. Groups of less than 20 employees.
2. Certain church plans.

For details, the Insured and/or dependent(s) must contact the person who handles the Employer's insurance matters.

SCHEDULE OF BENEFITS

(Continued)

Death or Divorce

For Dependents Only

This continuation applies to all Employers.

1. The Insured's spouse may continue coverage if it would stop because:

   a. the Insured dies; or

   b. the marriage is dissolved;

   provided:

   i. the spouse elects to do so;

   ii. election is made within 30 days of written notice from us; and

   iii. premium is paid within 30 days of receiving written notice.

   The spouse's continued insurance may include any dependent children whose insurance ends at the same time.

2. Benefits

   This continuation applies to Dental Expense Benefits.

3. Termination

   Such insurance will stop on the earliest of:

   a. the last day of the period for which the premium is paid;

   b. the date of coverage would normally stop under the terms of the Policy, except coverage must not be changed or stopped during the first 120 days of continuation unless coverage is changed or stopped for all employees covered under the Policy;

   c. the date the spouse becomes insured under another group health plan;

   d. the date the spouse remarries;

   e. the date coverage has been continued for two years, for spouse under age 55 when continuation started;

   f. the date the spouse or any dependent child is eligible for coverage under Medicare, Title XVIII of the Federal social Security Act; or

   g. the date the Policy terminates.

4. Replacement of Policy

   A new insurance carrier replacing coverage under which a continued person is covered must take over and continue such person's coverage.

5. Premium

If, at the time continuation starts, the spouse is:

a. less than 55, we may charge the full premium, i.e., the employee and employer's portion.

b. age 55 or over, we may charge the amount shown in a. above for the first two years. For future years, we may increase this amount by 20%.

6. How to Apply

a. Within 30 days after divorce or death, the spouse must notify both the employer and us if he or she wishes to continue.

b. Within 15 days of receipt of the notice in a. the employer will:

i. notify us by providing the spouse's name and address; and

ii. send a copy of this notice to the spouse.

c. Within 30 days of receipt of notice, we must send the spouse by certified mail, return receipt requested, notice of the continuation option including:

i. an election form;

ii. the premium due;

iii. when and how payments must be made; and

iv. instructions on returning the election form.

d. Within 30 days of receipt of the notice in c. above, if the spouse wants to elect continuation, the election form and the first monthly premium must be returned to us by certified mail, return receipt requested.

7. Failure to Notify

If we fail to send the election forms, then the spouse will receive free coverage until the notice is sent, unless the Policy is terminated.

DEFINITIONS

COMPANY is Companion Life Insurance Company. The words "we", "us" and "our" refer to Company. Our Home Office address is P.O. Box 100102 Columbia, SC 29202-31 02.

POLICYHOLDER means the Policyholder stated on the face page of the policy.

INSURED means a person:

a. who is an Employee of the Eligible Class for Personal Insurance; and

b. who has qualified for insurance by completing the waiting period, if any; and

c. for whom the insurance has become effective.

For the purpose of Dental Expense Benefits and Orthodontic Expense Benefits, if included, Insured also means any eligible dependent which the Insured has elected to enroll under the Policy.

DEPENDENT INSURANCE means insurance which provides benefits payable as a result of the treatment of a dependent of an Insured.

DEPENDENT means:

a. an Insured's spouse.

b. each unmarried child up to 26 years of age for whom the Insured is legally responsible.

c. each unmarried child over age 19 who:

i. becomes Totally Disabled while insured under b. or c. above;

ii. is incapable of self-sustaining employment because of mental retardation or physical handicap; and

is primarily dependent on the Insured for support and maintenance.

Coverage for such child will not cease if proof of dependency and disability is given within 31 days after the Company asks for it.

DEPENDENT UNIT means all the people who are insured as the dependents of any one Insured.

FAMILY means an Insured and all of his or her legal dependents.

ACTIVE SERVICE means the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full-time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

TOTAL DISABILITY means the complete inability of:

a. an Insured to perform the duties of any job for which he or she is reasonably fitted by education, training or experience. An Insured will not be Totally Disabled if he or she engages in any job for wage or profit.

b. a dependent to perform the normal activities of a person of like age and sex.

PERSONAL INSURANCE means insurance which provides benefits payable as a result of the treatment, disability, or death of an Insured.

PHYSICIAN means any person who is licensed by the law of the state in which treatment, within the scope of his or her license, is given for the sickness or injury causing the expenses or loss for which claim is made.

DENTAL HYGIENIST means a person who is licensed to practice dental hygiene and who is practicing within the scope of his or her license.

DENTAL PRACTITIONER means a dentist, dental hygienist or a denturist.

DENTIST means a person who is licensed to practice dentistry or oral surgery and who is practicing within the scope of his or her license.

DENTURIST means a person who is licensed to make, fit and repair dentures and who is practicing within the scope of his or her license.

LATE ENTRANT means any person:

a. whose Effective Date of insurance is more than 31 days from the date the person qualifies for insurance, or

b. who has elected to become insured again after cancelling a premium contribution agreement.

CONFINED in an institution means registered as a bed patient, unless stated otherwise.

CONTRACT YEAR means the period from the Effective Day of any year to the Effective Day of the following year.

EFFECTIVE DATE means the date coverage under the policy becomes effective. The Effective Date for the Policyholder is shown on the policy cover. The Effective Date for an Insured is shown on the individual certificate or is in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

EFFECTIVE DAY is the day of the Effective Date.

USUAL, CUSTOMARY, AND REASONABLE means the determination of payable benefits is developed from a statistically valid sample which (a) equitably recognizes geographic variations; (b) is produced at least every six months; and (c) is collected on the basis of the most current codes and descriptions developed and maintained by recognized authorities.

REPLACEMENT occurs when an employer’s coverage under a prior group dental insurance policy terminates within 15 days of commencement of coverage under the policy.

CONDITIONS FOR DEPENDENT INSURANCE
ELIGIBILITY

ELIGIBLE CLASS FOR DEPENDENT INSURANCE

The employees of the Eligible Class for dependent insurance are shown on the Schedule of Benefits.

Each Employee of the Eligible Class for Personal Insurance (referred to here as "Employee") will qualify for such insurance on the day he or she completes the required waiting period, if any.

WAITING PERIOD

The Waiting Period is shown on the Schedule of Benefits.

An Insured whose eligibility terminates and is established again within 12 months will not have to complete a new waiting period before he or she can qualify for Insurance.

PARTICIPATION REQUIREMENTS

In order for the Policy to be placed in force, and to remain in force, certain participation requirements must be met. These requirements are shown on the Schedule of Benefits.

CONTRIBUTION REQUIREMENTS

The contribution requirements are shown on the Schedule of Benefits.

EFFECTIVE DATE

Each Employee wanting to be insured must sign an enrollment card. We must approve the form to be used for the card. The Effective Date will be the first of the month on or next following:

1. the date on which he or she qualifies for Insurance, if we receive the signed enrollment card on or before that date.

2. the date we receive the signed enrollment card, if that date is after the date he or she qualifies for Insurance. If the Insured's Effective Date is more than 31 days after the first date he or she could have been effective, the Insured is a Late Entrant and subject to the Limitation concerning Late Entrants.

BENEFIT CLASSIFICATION CHANGE

If an Insured's status changes so that he or she becomes an Employee of a different Eligible Class, as shown in the Schedule of Benefits, any change in amounts of insurance because of the new class will take effect on the Effective Day of the month on or next following the change.

EXCEPTIONS

An Employee must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. For this paragraph, an Employee will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

(Continued)
TERMINATION DATE

The insurance on any Insured will automatically terminate on the end of the month falling on or next following the earliest of:

1. the date the Insured ceased to be an Employee;

2. the last day of the period for which the Insured has contributed, if required, to the payment of Insurance premiums;

3. 90 days after the number of Insureds falls below any participation requirements shown in the Schedule of Benefits; or

4. the date the policy is terminated.

CONTINUATION OF COVERAGE

If an Insured's coverage ceases according to TERMINATION DATE, the insurance coverage may be continued. See the Schedule of Benefits.

CONDITIONS FOR DEPENDENT INSURANCE
ELIGIBILITY

ELIGIBLE CLASS FOR DEPENDENT INSURANCE

The employees of the Eligible Class for dependent insurance are shown on the Schedule of Benefits.

Each employee of the Eligible Class for Dependent Insurance (referred to here as "Employee") is eligible for the Dependent Insurance (referred to here as "Insurance") under the policy and will qualify for this insurance on the latest of:

1. the day he or she qualifies for Personal Insurance;
2. the day he or she first becomes an Employee; or
3. the day he or she first has a dependent.

An employee must be insured for Personal Insurance to insure his or her dependents.

PARTICIPATION REQUIREMENTS

In order for the policy to remain in force for dependents, certain participation requirements must be met. These requirements are shown on the Schedule of Benefits.

CONTRIBUTION REQUIREMENTS

The contribution requirements are shown on the Schedule of Benefits.

EFFECTIVE DATE

Each Insured wishing to insure his or her dependents must sign an enrollment card. We must approve the form to be used for the card. The Effective Date for dependents will be the first of the month on or next following:

1. the date on which the Insured qualifies for Dependent Insurance, if we receive the signed enrollment card on or before that date.
2. the date we receive the signed enrollment card, if that date is after the date the Insured qualifies for Dependent Insurance. If we receive the enrollment card more than 31 days after the first date the Insured could have been effective for Dependent Insurance, each dependent is a Late Entrant and subject to the Limitation concerning Late Entrants.

(Continued)
TERMINATION DATE

The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the earliest of:

1. the date on which the Insured's Personal Insurance terminates.
2. the date on which the Insured ceases to be an Employee.
3. the last day of the period for which the Insured has contributed, if required, to the payment of Insurance premiums.
4. the date all Dependent Insurance under the policy is terminated.
5. the date all Dependent Insurance is cancelled for a specific Employer Unit.
6. the date the policy is terminated.

The insurance for any dependent will automatically terminate on the end of the month falling on or next following the date the dependent does not meet the definition of a dependent. See "Definitions."

CONTINUATION OF COVERAGE

If a dependent's coverage ceases according to TERMINATION DATE, the insurance coverage may be continued. See the Schedule of Benefits.

PERSONAL AND DEPENDENT DENTAL CARE INSURANCE

DENTAL EXPENSE BENEFITS

If an Insured under this section incurs Covered Expenses, we will pay benefits as stated below. The benefits will be determined as follows:

a. the Covered Expenses reported are separated into the correct Class of procedure;
b. then, the Deductible Amount is applied, if any;
c. the remaining amount for each Class is then multiplied by the Coinsurance Percentage for each Class shown in the Schedule of Benefits.

DEDUCTIBLE AMOUNT. The Deductible Amount shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be paid for only those Covered Expenses which are more than the Deductible amount.

MAXIMUM AMOUNT. The Maximum Benefit per Contract Year shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured each Contract Year.

PREDETERMINATION OF BENEFITS. If the cost of dental treatment for a family member is to exceed two-hundred dollars ($200.00), a treatment plan must be sent to us before treatment begins. We review the plan and determine the expenses that are covered. We then return the plan to the dental practitioner, showing the amount we expect to pay. We pay only for the procedures that are actually rendered while the family member is insured for this benefit.

No treatment plan is needed for emergency care of an accidental injury or for expenses of two-hundred dollars or less.

COVERED EXPENSES. Covered Expenses means the usual, customary and reasonable expenses as determined by us incurred by an Insured for the Class I - Preventive, Class II - Basic and Class III -Major Procedures shown on the List of Dental Procedures. But such expenses will be Covered Expenses only to the extent that they are incurred for procedures done by a dentist, dental hygienist, or denturist. These expenses are subject to the "Limitations" below.

ALTERNATIVE PROCEDURES. If two or more procedures are adequate and appropriate treatment to correct a certain condition, the amount of the Covered Expense will be the charge for the least expensive procedure.

We may ask that pre-operative dental x-rays be given to us to decide if we are liable for the procedures submitted for consideration. If the x-rays are not given to us, we will have to decide the procedures which would provide professionally adequate restoration, replacement or treatment. If we then receive the pre-operative dental x-rays and decide that different procedures are more appropriate we will make adjustments that we deem are proper.

START DATE FOR PROCEDURES. For a denture, partial denture, or other appliance or a change to any appliance (other than a fixed bridge), the procedure starts at the time the impression is made. For a fixed bridge or a crown, inlay, onlay, or other precious or semiprecious metal restoration, the procedure starts at the time the tooth or teeth are prepared. For root canal therapy, the procedure starts at the time the pulp chamber is opened. For any other procedure requiring more than one session to complete, the procedure starts at the time of the first session. For any procedure requiring only one session to complete, the procedure starts at the time the service is rendered or the supply is furnished.

INCURRED DATE FOR EXPENSES. For a denture, partial denture, implant, fixed bridge, other appliance, crown, inlay, onlay, or other precious or semiprecious metal restoration (whether the item is new, replacement, repaired, or modified), the expense is incurred at the time of final placement of the item. For root canal therapy, the expense is incurred at the time the root canal is completed. For any other procedure requiring more than one session to complete, the expense is incurred at the time the last session is completed. For any procedure requiring only one session to complete, the expense is incurred at the time the service is rendered or the supply is furnished.

LIMITATIONS.

I. Covered Expenses will not include and no benefits will be payable:

LIMITATIONS (Continued).

1. for Class III Procedures in the first 12 months that the insured is covered under this plan except:

    a. when this plan replaces the insured's coverage under the employer's prior plan;
    b. the prior plan contained similar benefits for Class III Procedures as this plan;
    c. the prior plan had been in effect for at least 18 months; and
    d. takeover benefits have been approved by Companion Life.

2. in the first twelve months that a person is insured if the person is a Late Entrant; except for exams, cleanings and fluoride application.

3. for any treatment which is for cosmetic purposes, or to correct congenital malformations, other than medically necessary treatment of congenital cleft in the lip or palate, or both.

4. to replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement of these items. Replacement of an existing implant supported prosthetic device is covered only once every ten (10) years from the placement date of such device and only then if it is unserviceable and cannot be made serviceable. But if a replacement is required because of an accidental bodily injury sustained while the Insured is covered under this section, it will be a Covered Expense.

5. for initial placement of any prosthetic appliance, implants or fixed bridge unless such placement is needed because of the extraction of one or more natural teeth while the Insured is covered under this section. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth.

6. for any procedure begun before the Insured was covered under this section.

7. for any procedure begun after the Insured's insurance under this section terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this section terminates.

8. to replace lost or stolen appliances.

9. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion;
    c. splint or replace tooth structure lost as a result of abrasion or attrition; or
    d. treat disturbances of the temporomandibular joint.

10. for any procedure which is not shown on the List of Dental Procedures.

11. for education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.

12. for the completion of claim forms.

13. for orthodontia service, Class IV, when this optional coverage is not elected and the premium is not paid.

    In any event, orthodontia covered charges will not include charges:
    a. incurred by employee or spouse; or
    b. incurred by a dependent child age 19 or over (unless optional Adult Orthodontia Benefit is Selected); or
    c. for any services payable under any other provisions of the policy; or
    d. for any services in the first 12 months the insured person is covered under the policy.

14. for sealants which are:

LIMITATIONS (Continued).

a. not applied to a permanent molar.
b. applied after attaining age 17.
c. reapplied to a molar within 3-years from the date of a previous sealant application.

15. subgingival curettage or root planing (procedure numbers 4220, and 4341) unless the presence of periodontal disease is confirmed by both x-rays and pocket depth summaries of each tooth involved.

16. because of an injury arising out of, or in the course of, work for wage or profit.

17. by an Insured because of a sickness, injury or condition for which he or she is eligible for benefits under any Worker's Compensation act or similar laws.

18. for charges for which the Insured is not liable or which would not have been made had no insurance been in force.

19. for services which are not recommended by a dentist or which are not required for necessary care and treatment.

20. because of war or any act of war, declared or not.

21. to an Insured if payment is not legal where the Insured is living when expenses are incurred.

22. Any services related to: equilibration; bite registration or bite analysis.

23. Crowns for the purpose of periodontal splinting.

24. Charges for: precision or semi-precision attachments, and any endodontic treatment associated with it; or other customized attachments.

II. Payment For Services During The First 12 Months Shall Be Limited As Follows:

If:

(1) this plan replaces the insured's coverage under the employer's prior plan;
(2) the prior plan contained similar benefits as this plan; and
(3) this results in continuous coverage, then, we limit what we pay to the lesser of:

(a) what the prior plan would have paid; or
(b) what this plan would usually pay. We will deduct any benefits actually paid by the prior plan under any extension provision.

PERSONAL AND DEPENDENT DENTAL CARE INSURANCE

LIST OF COVERED DENTAL EXPENSE PROCEDURES

The following is a complete list of the dental procedures for which benefits are payable under this section. No benefits are payable for a procedure that is not listed.

CLASS I PROCEDURES - PREVENTIVE

PROC. NO.	***DESCRIPTION OF SERVICE***
*****ORAL EVALUATION (EXAMINATION) AND PROPHYLAXIS (CLEANING)**. Oral evaluation is limited to twice in any 12-month period. Prophylaxis is limited to twice in any 12-month period. Fluoride application is limited to once in any 12-month period.	
0120	Periodic oral evaluation
0140	Limited oral evaluation, problem focused
0150	Comprehensive oral evaluation
0160	Detailed and extensive oral evaluation, problem focused, by report
0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)
1110	Prophylaxis for individuals age 12 and over, treatment to include scaling and polishing
1120	Prophylaxis for children under age 12
1201	Topical application of fluoride with prophylaxis (only for children under age 19)
1203	Topical application of fluoride without prophylaxis (only for children under age 19)
*****X-RAYS.**	
0270	**Bitewings, single film
0272	**Bitewings, two films
0274	**Bitewings, four films
0277	Vertical bitewings - 7 to 8 films

**Only one series of bitewings will be allowed in any 12-month period.

PERSONAL AND DEPENDENT DENTAL CARE INSURANCE

LIST OF COVERED DENTAL EXPENSE PROCEDURES (Continued)

CLASS II PROCEDURES - BASIC

PROC. NO.	***DESCRIPTION OF SERVICE***
1351	Sealant, per tooth (once in any 36 month period, only for permanent molars, only for children at least 6, but less than 16, years of age)

*****X-RAYS.**

0210	*Intraoral, complete series (including any bitewings)
0220	Intraoral, periapical, first film
0230	Intraoral, periapical, each additional film (benefit for a single series of 0220 and 0230 films, including any bitewings, not to exceed benefit for a single 0210 series).
0240	Intraoral, occlusal film
0250	Extraoral, first film
0260	Extraoral, each additional film
0290	Posterior/anterior/lateral skull and facial bone survey
0330	*Panoramic film
0350	Oral/facial photographic images (includes intro and extraoral images)

*Only one of the two procedures 0210 and 0330 will be allowed in any 36 month period.

SPACE MAINTAINERS. Fee includes all adjustments within six months after installation. Allowable only for the purpose of maintaining spaces created by extractions of primary teeth or unerupted teeth.

1510	Fixed space maintainer, unilateral
1515	Fixed space maintainer, bilateral
1520	Removal space maintainer, unilateral
1525	Removable space maintainer, bilateral
1550	Recementation of space maintainer

BASIC RESTORATIONS (FILLINGS), excluding inlays, onlays, crowns and bridges.

Amalgam Restorations

2140	One surface, primary or permanent
2150	Two surfaces, primary or permanent
2160	Three surfaces, primary or permanent
2161	Four or more surfaces, primary or permanent

Resin Restorations. Benefit for resin restoration of a posterior tooth not to exceed benefit for amalgam restoration of the same tooth involving the same number of surfaces

2330	Resin-based composite, one surface, anterior
2331	Resin-based composite, two surfaces, anterior
2332	Resin-based composite, three surfaces, anterior
2335	Resin-based composite, four or more surfaces or involving incisal angle, anterior
2390	Resin-based composite crown, anterior
2391	Resin-based composite - one surface, posterior
2392	Resin-based composite - two surfaces, posterior
2393	Resin-based composite - three surfaces, posterior
2394	Resin-based composite - four or more surfaces, posterior

TREATMENT OF PAIN

2940	Sedative filling
9110	Emergency palliative treatment of dental pain, minor procedures

PROC. NO. ***DESCRIPTION OF SERVICE***

*****OTHER DIAGNOSTIC PROCEDURES.**

0460 Pulp vitality tests.
0470 Diagnostic casts.
0350 Oral/facial photographic images.

***X-rays, oral evaluations, and other diagnostic procedures are not covered if preliminary to, or otherwise associated with, orthodontic therapy unless the Participating Employer elects the optional orthodontic coverage and pays the required premium.

MAJOR RESTORATIONS (FOIL, INLAYS, ONLAYS, CROWNS), covered only when needed due to decay or traumatic injury.

Foil, Inlays and Onlays.

2410 Gold foil, one surface.
2420 Gold foil, two surfaces.
2430 Gold foil, three or more surfaces.
2510 Inlay, metallic, one surface.
2520 Inlay, metallic, two surfaces.
2530 Inlay, metallic, three or more surfaces.
2542 Onlay, metallic-two surfaces
2543 Onlay, metallic, three surfaces.
2544 Onlay, metallic, four or more surfaces.
2610 Inlay, porcelain/ceramic, one surface.
2620 Inlay, porcelain/ceramic, two surfaces.
2630 Inlay, porcelain/ceramic, three or more surfaces.
2642 Onlay, porcelain/ceramic, two surfaces.
2643 Onlay, porcelain/ceramic, three surfaces.
2644 Onlay, porcelain/ceramic, four or more surfaces.
2650 Inlay, composite/resin, one surface (laboratory processed).
2651 Inlay, composite/resin, two surfaces (laboratory processed).
2652 Inlay, composite/resin, three or more surfaces (laboratory processed).
2662 Onlay, composite/resin, two surfaces (laboratory processed).
2663 Onlay, composite/resin, three surfaces (laboratory processed).
2664 Onlay, composite/resin, four or more surfaces (laboratory processed).

Crowns and Related Procedures.

2710 Crown, resin-based composite (indirect).
2712 Crown, 3/4 resin-based composite (indirect).
2720 Crown, resin with high noble metal.
2721 Crown, resin with predominantly base metal.
2722 Crown, resin with noble metal.
2740 Crown, porcelain/ceramic substrate.
2750 Crown, porcelain fused to high noble metal.
2751 Crown, porcelain fused to predominantly base metal.
2752 Crown, porcelain fused to noble metal.
2780 Crown - 3/4 cast high noble metal
2781 Crown - 3/4 cast predominately base metal
2782 Crown - 3/4 cast noble metal
2783 Crown - 3/4 porcelain/ceramic (This code does not include facial veneers.)
2790 Crown, high noble metal, full cast.
2791 Crown, predominantly base metal, full cast.
2792 Crown, noble metal, full cast.

PROC. NO.	***DESCRIPTION OF SERVICE***
2794	Crown, titanium.
2930	Prefabricated stainless steel, primary tooth.
2931	Prefabricated stainless steel, permanent tooth (available to children under age 19 only).
2932	Prefabricated resin crown (available to children under age 19 only).
2933	Prefabricated stainless steel crown with resin window (available to children under age 19 only).
2934	Prefabricated esthetic coated stainless steel crown - primary tooth.
2950	Core build-up, including any pins.
2951	Pin retention, per tooth, in addition to restoration
2952	Cast post and core in addition to crown
2953	Each additional cast post - same tooth
2954	Prefabricated post and core in addition to crown.
2955	Post removal, not in conjunction with endodontic therapy
2957	Each additional prefabricated post - same tooth
2971	Additional procedures to construct new crown under partial.

PROC.
NO. ***DESCRIPTION OF SERVICE***

RECEM ENTATION

2910 Inlay.
2920 Crown.
6930 Recementation of bridge.

BASIC ENDODONTICS, including necessary X-rays and cultures but excluding final restoration

Endodontic Therapy, limited to use on primary teeth only
3110 Direct pulp cap
3120 Indirect pulp cap
3220 Therapeutic pulpotomy
3221 Pulpal debridement, primary and permanent teeth
3230 Resorbable-filling pulpal therapy, anterior
3240 Resorbable-filling pulpal therapy, posterior

Root Canals, limited to use on permanent teeth only
3310 Anterior (one canal)
3320 Biscuspid (two canals)
3330 Molar (three canals)
3331 Treatment of root canal obstruction; non-surgical access
3332 Incomplete endodontic therapy; inoperable or fractured tooth
3333 Internal root repair of perforation defects
3346 Retreatment of previous root canal therapy, anterior
3347 Retreatment of previous root canal therapy, biscuspid
3348 Retreatment of previous root canal therapy, molar

DENTURE REPAIRS. Repair
of Complete Dentures
5510 Repair broken base
5520 Replace missing or broken teeth, each tooth

Repair of, or Additions to, Partial Dentures
5610 Repair resin base
5620 Repair cast framework
5630 Repair or replace broken clasp
5640 Replace broken teeth, per tooth
5650 Add tooth to existing partial
5660 Add clasp to existing partial

****ORAL SURGERY,** including any local anesthesia and routine post-operative visits.

Simple Extractions
7111 Coronal remnants- deciduous tooth
7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Surgical Extractions.
7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.
7220 Removal of impacted tooth, soft tissue.
7230 Removal of impacted tooth, partially bony.
7240 Removal of impacted tooth, completely bony.

PROC. NO.	***DESCRIPTION OF SERVICE***
7241	Removal of impacted tooth, completely bony, with unusual surgical complications.
7250	Surgical removal of residual tooth roots.
Removal of Cysts and Neoplasms	
7285	Biopsy of oral tissue, hard (bone, tooth)
7286	Biopsy of oral tissue, soft (all others)
7287	Exfoliative cytological sample for collection of non-transepitheleal cytolgy sample, mild scraping.
7288	Brush biopsy – transepithelial sample collection.
7410	Excision of benign lesion up to 1.25 cm.
7411	Excision of benign lesion greater than 1.25cm.
7412	Excision of benign lesion, complicated
7413	Excision of malignant lesion up to 1 .25cm
7414	Excision of malignant lesion greater than 1.25cm
7415	Excision of malignant lesion, complicated
7440	Excision of malignant tumor, up to 1.25 cm
7441	Excision of malignant tumor, over 1.25 cm
7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm
7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm
7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm
7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1 .25 cm
7465	Destruction of lesion(s) by physical or chemical method, by report
7510	Incision and drainage of abscess, intraoral soft tissue.
7511	Incision and drainage of abscess, intraoral soft tissue, complicated.
7520	Incision and drainage of abscess, extraoral soft tissue.
7521	Incision and drainage of abscess, extraoral soft tissue, complicated.
Other Oral Surgical Procedures	
7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth
7272	Tooth transplantation (includes re-implantation from one site to another and splinting and/or stabilization)
7280	Surgical access of an unerupted tooth
7282	Mobilization of erupted or malpositioned tooth to aid eruption
7290	Surgical repositioning of teeth
7291	Transseptal fiberotomy/supra crestal fiberotomy, by report
7960	Frenulectomy (frenectomy or frenotomy) as a separate procedure
7963	Frenuloplasty, excision of frenum with accompanying excision or repositioning of aberrant muscle.

****ANESTHESIA,** when administered by the dentist in the dentist's office (not covered unless a cutting procedure is being performed at that time) with medical review.

9220	Deep sedation/general anesthesia – first 30 minutes
9241	Intravenous conscious sedation/analgesia – first 30 minutes

**Oral surgery and anesthesia are not covered if preliminary to, or otherwise associated with, orthodontic therapy unless the Participating Employer elects the optional orthodontic coverage and pays the required premium.

MAJOR ENDODONTICS. Endodontic surgical procedures include any local anesthesia and routine post-operative visits.

3351	Apexification/recalcification, initial visit
3352	Apexification/recalcification, interim visit
3353	Apexification/recalcification, final visit
3410	Apicoectomy/periradicular surgery, anterior (single root)

PROC. NO.	***DESCRIPTION OF SERVICE***
3421	Apicoectomy/periradicular surgery, biscuspid, first root
3425	Apicoectomy/periradicular surgery, molar, first root
3426	Apicoectomy/periradicular surgery, biscuspid or molar, each additional root
3430	Retrograde filling, per root
3450	Root amputation, per root
3460	Endodontic osseous implant
3470	Intentional replantation, including necessary splinting
3920	Hemisection, including any root removal but not including root canal therapy

PERIODONTICS. Periodontic surgical procedures include any local anesthesia and routine post-operative visits.

0180	Comprehensive periodontal evaluation.
4210	Gingivectomy or gingivoplasty, four or more contiguous teeth or bounded teeth spaces per quadrant
4211	Gingivectomy or gingivoplasty, one to three teeth, per quadrant
4240	Gingival flap procedure, including root planing, four or more contiguous teeth or bounded teeth spaces per quadrant
4241	Gingival flap procedure, including root planing, one to three teeth, per quadrant
4245	Apically positioned flap
4249	Clinical crown lengthening, hard tissue
4260	Osseous surgery, including flap entry and closure, four or more contiguous teeth or bounded teeth spaces per quadrant
4261	Osseous surgery, including flap entry and closure, one to three contiguous teeth per quadrant.
4263	Bone replacement graft, first site in quadrant
4264	Bone replacement graft, each additional site in quadrant
4265	Biologic materials to aid in soft and osseous tissue regeneration
4266	Guided tissue regeneration, resorbable barrier, per site, per tooth
4267	Guided tissue regeneration, nonresorbable barrier, per site, per tooth (includes membrane removal)
4268	Surgical revision procedure, per tooth.
4270	Pedicle soft tissue graft procedure
4271	Free soft tissue graft procedure, including donor site surgery
4273	Subepithelial connective tissue graft procedure, including donor site surgery
4274	Distal or proximal wedge procedure when not performed in conjunction with surgical procedures in the same anatomical area
4275	Soft tissue allograft
4276	Combined connective tissue and double pedicle graft
4320	Provisional splinting, intracoronal
4321	Provisional splinting, extracoronal
4341	Periodontal scaling and root planing, four or more contiguous teeth or bounded teeth spaces per quadrant
4342	Periodontal scaling and root planing - one to three teeth, per quardrant
4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis
4381	Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report
4910	Periodontal maintenance

REMOVABLE PROSTHODONTICS (PARTIAL AND COMPLETE DENTURES). Fees for both partial and complete dentures and relining include adjustments within 6 months after installation. Relines are not covered until more than 6 months after installation. Adjustments are not covered as separate procedures until more than 6 months after installation. Precision attachments, overdentures, specialized techniques, and characterizations are considered optional and the additional expense for these shall be borne by the patient. All partials include conventional clasps, rests, and teeth.

PROC. NO.	***DESCRIPTION OF SERVICE***
5110	Complete upper denture
5120	Complete lower denture
5130	Immediate upper denture
5140	Immediate lower denture
5211	Upper partial, resin base
5212	Lower partial, resin base
5213	Upper partial, cast metal frame with resin base
5214	Lower partial, cast metal frame with resin base
5225	Maxillary partial denture.
5226	Mandibular partial denture.
5281	Removable unilateral partial, one piece cast metal
5410	Adjust complete upper denture
5411	Adjust complete lower denture
5421	Adjust upper partial
5422	Adjust lower partial
5710	Rebase complete upper denture
5711	Rebase complete lower denture
5720	Rebase upper partial
5721	Rebase lower partial
5730	Office reline, complete upper denture
5731	Office reline, complete lower denture
5740	Office reline, upper partial
5741	Office reline, lower partial
5750	Lab reline, complete upper denture
5751	Lab reline, complete lower denture
5760	Lab reline, upper partial
5761	Lab reline, lower partial
5860	**Complete overdenture, by report
5861	**Partial overdenture, by report

**Benefit for overdenture not to exceed benefit for corresponding denture (complete or partial, upper or lower).

FIXED PROSTHODONTICS (BRIDGES).

Pontics.

6205	Pontic, indirect resin-based composite.
6210	Cast high noble metal.
6211	Cast predominantly base metal.
6212	Cast noble metal.
6214	Pontic, titanium.
6240	Porcelain fused to high noble metal.
6241	Porcelain fused to predominantly base metal.
6242	Porcelain fused to noble metal.
6250	Resin with high noble metal.
6251	Resin with predominantly base metal.
6252	Resin with noble metal

Retainers.

6520	Inlay, metallic, two surfaces.
6530	Inlay, metallic, three or more surfaces.
6543	Onlay, metallic, three surfaces.
6544	Onlay, metallic, four or more surfaces.

PROC. NO.	***DESCRIPTION OF SERVICE***
6545	Cast metal, for resin bonded fixed prosthesis (bridge to include maximum of one pontic and two metal retainers).
6600	Inlay, porcelain/ceramic, two surfaces
6601	Inlay, porcelain/ceramic, three or more surfaces
6602	Inlay, cast high noble metal, two surfaces
6603	Inlay, cast high noble metal, three or more surfaces
6604	Inlay, cast predominantly base metal, two surfaces
6605	Inlay, cast predominantly base metal, three or more surfaces
6606	Inlay, cast noble metal, two surfaces
6607	Inlay, cast noble metal, three or more surfaces
6608	Onlay, porcelain/ceramic, two surfaces
6609	Onlay, porcelain/ceramic, three or more surfaces
6610	Onlay, cast high noble metal, two surfaces
6611	Onlay, cast high noble metal, three or more surfaces
6612	Onlay, cast predominantly base metal, two surfaces
6613	Onlay, cast predominantly base metal, three or more surfaces
6614	Onlay, cast noble metal, two surfaces
6615	Onlay, cast noble metal, three or more surfaces
6624	Inlay, titanium.
6634	Onlay, titanium.
6710	Crown, indirect resin-based composite
6720	Crown, resin with high noble metal.
6721	Crown, resin with predominantly base metal.
6722	Crown, resin with noble metal.
6750	Crown, porcelain fused to high noble metal.
6751	Crown, porcelain fused to predominantly base metal.
6752	Crown, porcelain fused to noble metal.
6780	Crown, 3/4 cast high noble metal.
6790	Crown, full cast high noble metal.
6791	Crown, full cast predominantly base metal.
6792	Crown, full cast noble metal.
6794	Crown, titanium.
6940	Stress breaker.
6970	Cast post and core in addition to bridge retainer.
6971	Cast post as part of bridge retainer.
6972	Prefabricated post and core in addition to bridge retainer.
6973	Core build-up for retainer, including any pins.
6976	Each additional cast post, same tooth
6977	Each additional prefabricated post - same tooth

OTHER MAJOR SERVICES.

Repairs, Crowns and Bridges.

2980	Crown repair, by report.
6980	Bridge repair, by report.

Alveolar or Gingival Reconstruction, including any local anesthesia and routine post-operative visits.

7310	Alveoplasty in conjunction with extractions, per quadrant
7311	Alveoplasty in conjunction with extractions, one to three teeth or tooth spaces.
7320	Alveoplasty not in conjunction with extractions, per quadrant.
7321	Alveoplasty not in conjunction with extractions, one to three teeth or tooth spaces.
7340	Vestibuloplasty, ridge extension (secondary epithelialization)

PROC. NO.	***DESCRIPTION OF SERVICE***
7350	Vestibuloplasty, ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hyperplastic tissue)
7970	Excision of hyperplastic tissue, per arch
7971	Excision of pericoronal gingiva

IMPLANT SERVICES. Available to adults and dependent children age 17 and older. Implant Services include the accompanying crown and are incurred on final placement of the prosthetic. No benefit will be provided for implants or implant services where loss of the tooth was prior to the Insured's effective date of coverage under this dental plan.

Surgical Placement Implants.

D6010	Surgical placement of implant body: endosteal implant.
D6040	Surgical placement: eposteal implant.
D6050	Surgical placement: transosteal implant.

Implant Supported Prosthetics.

D6055	Dental implant supported connecting bar.
D6056	Prefabricated abutment – includes placement.
D6057	Custom abutment – includes placement.
D6058	Abutment supported porcelain/ceramic crown.
D6059	Abutment supported porcelain fused to metal crown (high noble metal).
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061	Abutment supported porcelain fused to metal crown (noble metal).
D6062	Abutment supported cast metal crown (high noble metal).
D6063	Abutment supported cast metal crown (predominantly base metal).
D6064	Abutment supported cast metal crown (noble metal).
D6094	Abutment supported crown - (titanium).
D6065	Implant supported porcelain/ceramic crown.
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).
D6068	Abutment supported retainer for porcelain/ceramic FPD.
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072	Abutment supported retainer for cast metal FPD (high noble metal).
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).
D6074	Abutment supported retainer for cast metal FPD (noble metal).
D6194	Abutment supported retainer crown for FPD - (titanium).
D6075	Implant supported retainer for ceramic FPD.
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal).
D6078	Implant/abutment supported fixed denture for completely edentulous arch.
D6079	Implant/abutment supported fixed denture for partially edentulous arch.

Replacement of an existing implant supported prosthetic device is covered only once every ten (10) years from the placement date of such device and only then if it is unserviceable and cannot be made serviceable.

Other Implant Services.

D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis.
D6100	Implant removal, by report.
D6190	Radiographic/Surgical implant index, by report.
D6199	Unspecified implant procedure, by report.

PROC. NO.	***DESCRIPTION OF SERVICE***
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla
D7953	Bone replacement graft for ridge preservation

LIST OF COVERED DENTAL EXPENSE PROCEDURES (Continued)

CLASS IV PROCEDURES - ORTHODONTICS

PROC. NO.	***DESCRIPTION OF SERVICE***

Class IV procedures are not covered unless the Employer elects the optional orthodontic coverage (as shown in the Schedule of Benefits) and pays the required premium. In any event, orthodontic coverage is not available for employees or spouses, or for dependent children age 19 or older.

7283	Placement of device to facilitate eruption of impacted teeth.
8010	Limited orthodontic treatment of the primary dentition
8020	Limited orthodontic treatment of the transitional dentition
8030 or 8040	Limited orthodontic treatment of the permanent dentition
8050	Interceptive orthodontic treatment of the primary dentition
8060	Interceptive orthodontic treatment of the transitional dentition
8070	Comprehensive orthodontic treatment of the transitional dentition
8080 or 8090	Comprehensive orthodontic treatment of the permanent dentition
8420	Orthodontic monthly adjustment
8660	Pre-orthodontic treatment visit
8670	Periodic orthodontic treatment (as part of contract)
8690	Orthodontic treatment (alternative billing to a contract fee)

PERSONAL AND DEPENDENT DENTAL CARE INSURANCE

NON-COVERED PROCEDURES

No benefits are payable for procedures that are not listed in one of the above classes of procedures. Following are examples of some of the procedures not listed in one of the above classes, and for which no benefits are payable:

PROC. NO.	***DESCRIPTION OF SERVICE***
0310	Sialography.
0320	Temporomandibular joint (TMJ) arthrogram, including injection.
0321	X-rays, other temporomandibular joint (TMJ) films, by report.
0322	X-rays, tomographic survey.
0340	X-rays, cephalometric film.
0415	Sterilization or infection control, or bacteriologic studies for determination of pathologic agents.
0425	Caries susceptibility test.
0502	Other oral pathology procedures, by report.
1204 --- 1205	Topical application of fluoride for individuals age 19 and over
1310	Nutritional counseling for the control or prevention of dental disease.
1320	Tobacco counseling for the control or prevention of oral disease.
1330	Oral hygiene instruction.
2960 --- 2962	Labial veneers.
2970	Temporary crown (for fractured tooth).
2975	Coping.
3910	Surgical procedure for isolation of tooth with rubber dam.
3950	Canal preparation and fitting of preformed dowel or post.
3960	Bleaching of discolored tooth.
4920	Unscheduled dressing change by someone other than treating dentist.
5670	Replace all teeth and acrylic on cast metal framework (maxillary)
5671	Replace all teeth and acrylic on cast metal framework (mandibular)
5810 --- 5821	Interim dentures.
5850 --- 5851	Tissue conditioning.
5862	Precision attachment, by report.
5911 --- 5999	Various prostheses and related procedures.
6053	Implant/abutment supported removable denture for completely edentulous arch.
6054	Implant/abutment supported removable denture for partially edentulous arch.
6090	Repair implant supported prosthesis, by report.
6095	Repair implant abutment, by report.
6920	Connector bar.
6950	Precision attachment.
6975	Metal coping.
7480	Partial ostectomy (guttering or saucerization).
7490	Radical resection of mandible with bone graft.
7530	Removal of foreign body, skin, or subcutaneous tissue.
7540	Removal of reaction-producing foreign bodies from musculoskeletal system.
7550	Sequestrectomy for osteomyelitis.
7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.
7610 --- 7780	Various procedures for reduction of fractures.
7810 --- 7899	Various procedures related to the temporomandibular joint.
7910 --- 7912	Suture of wounds.
7920	Skin grafts.
7940 --- 7949	Various osteoplastic, osteotomic, and grafting procedures for repair of defects.
7955	Repair of maxillofacial soft and hard tissue defect.
7980 --- 7983	Various procedures related to the salivary gland.
7990	Emergency tracheotomy.
7991	Coronoidectomy.
7995	Synthetic graft, mandible or facial bones, by report.
7996	Mandible implant for augmentation purposes (excluding alveolar ridge), by report.
8210 --- 8220	Appliance therapy to control harmful habits

PERSONAL AND DEPENDENT DENTAL CARE INSURANCE

NON-COVERED PROCEDURES (Continued)

PROC. NO.	***DESCRIPTION OF SERVICE***
8691	Repair of orthodontic appliance
8692	Replacement of lost or broken retainer
9210	Local anesthesia not in conjunction with operative or surgical procedures
9211	Regional block anesthesia
9212	Trigeminal block anesthesia
9215	Local anesthesia
9221	Deep sedation/general anesthesia, each additional 15 minutes
9230	Analgesia
9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
9410	House call
9420	Hospital call
9430	Office visit for observation during regularly scheduled office hours with no other services performed
9440	Office visit after regularly scheduled office hours
9450	Cast presentation, detailed and extensive treatment planning
9610	Therapeutic drug injection, by report
9630	Other drugs and/or medicaments, by report
9910	Application of desensitizing medicament
9920	Behavior management, by report
9930	Treatment of postsurgical complications, unusual circumstances, by report
9940	Occlusal guard, by report
9941	Fabrication of athletic mouthguard
9942	Repair and/or reline of occlusal guard.
9950	Occlusion analysis, mounted case
9951 --- 9952	Occlusal adjustment
9970	Enamel microabrasion

COORDINATION OF BENEFITS

If an Insured is also covered under one or more other Plans, the benefits payable under this Plan will be coordinated with the benefits payable under those Plans.

BENEFITS SUBJECT TO COORDINATION. All benefits covered under two or more Plans will be coordinated except;

1. Life Insurance; and

2. Accidental Death, Dismemberment and Loss of Sight Insurance; and

3. Short-Term Disability Benefits.

EFFECT ON BENEFITS. When coordination applies, we adjust the benefits payable for any Claim Determination Period (period) as follows. The benefits that would be payable for Allowable Expenses incurred in that period under this Plan without coordination are reduced so that the sum of those reduced benefits and the benefits payable for those Allowable Expenses under all other Plans, whether or not claim is made, will not exceed the Allowable Expenses.

If, when we coordinate the benefits of this Plan with those of another Plan, (1) the rules set forth below would require this Plan to set its benefits before the other Plan; and (2) the other Plan coordinates benefits and would set its benefits after the benefits of this Plan have been set; then the benefits of that other Plan will be ignored when setting the benefits of this Plan.

ORDER OF BENEFIT DETERMINATION. The rules used to determine which of the Plans will pay benefits first are:

1. The benefits of a Plan with no coordination will set its benefits before a Plan with coordination.

2. The benefits of a Plan which covers the person other than as a dependent will be set before the benefits of a Plan which covers that person as a dependent.

3. If the claim is made for a dependent child whose parents are not separated or divorced, the benefits of a Plan that covers a child as a dependent of a person whose month and day of birth occurs earlier in a calendar year will be set before the benefits of a Plan that covers that child as a dependent of a person whose month and day of birth occurs later in a calendar year.

   If the month and day of birth of both parents is the same, then the Plan which has covered the parent for the longer period of time will pay its benefits first.

   If the other plan has a rule based on gender of the parent and, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

4. If the claim is made for a dependent child whose parents are separated or divorced, benefits for the child are determined in this order.

   a. first, the Plan of the parent with custody of the child;

   b. then, the Plan of the spouse of the parent with custody of the child; and

   c. finally, the Plan of the parent not having custody of the child.

   But, if there is a court decree which sets financial responsibility for the medical, dental or other health care expenses for the child, the benefits of a Plan which covers the child as a dependent of the parent who is responsible shall be set before the benefits of any other Plan which covers the child as a dependent child.

5. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) will be set before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of the benefits, then this rule is ignored.

6. When the rules above do not apply, the benefits of a Plan which has covered the person for the longer period of time will set before the benefits of a Plan which has covered the person the shorter period of time.

When the benefits of this Plan are reduced, each benefit is reduced, in proportion. It is then charged against any applicable benefit limit of this Plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. We may give or get from any other organization or person any information necessary to decide whether coordination applies. This may be done without the consent of the Insured. Any person claiming benefits under this Plan will be required to give us any information necessary to coordinate benefits.

FACILITY OF PAYMENT. When other Plans make payments which should have been made under this Plan according to the above terms, we will, at our discretion, pay to any organizations making these payments any amounts that we decide will satisfy the intent of the above terms. Amounts paid in this way will be benefits paid under this Plan. We will not be liable to the extent of these payments.

RIGHT OF RECOVERY. When we make payments for Allowable Expenses in excess of the amount that will satisfy the intent of the above terms, we will recover these payments, to the extent of the excess, from any persons or organizations to or for whom payments were made.

DEFINITIONS. The following apply only to this provision of the policy:

1. "Plan" means any of these types of coverage providing medical or dental benefits or services:

   a. group insurance or group type coverage; whether insured or uninsured. This includes:

      i. Blue Cross and Blue Shield

      ii. blanket (other than school accident-type coverage)

      iii. Health Maintenance Organizations (HMO's)

      iv. other prepayment, group practice and individual practice plans.

   b. any coverage under a governmental plan or required or provided by law, except Medicaid.

   Each type of coverage in a. or b. above is a separate Plan. If an arrangement has two or more parts and this coordination applies to only one part, each of the parts is a separate plan.

2. "Allowable Expense" means any necessary, reasonable and customary expense at least a part of which is covered under at least one of the Plans covering the person for whom claim is made.

   When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be both an Allowable Expense and a benefit paid.

3. "Claim Determination Period" means a contract year or that part of a contract year during which the person for whom claim is made has been covered under this Plan.

COORDINATION OF BENEFITS

NOTICE OF CLAIM. Written notice of claim must be given to us within 20 days after the accident causing the injury or, in the case of sickness, within 20 days after the event on which claim is based.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it will not be reasonably possible to give written notice within the 20 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the date of the loss for which claim is made. If it was not reasonably possible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

PHYSICAL EXAMINATION. We can examine any pre-operative dental x-rays while a dental claim is pending to determine the proper procedures to be considered.

TIME OF PAYMENT. We will pay all benefits within 30 days after receipt of due proof. If we fail to pay benefits within this 30 day period, the Insured is entitled to interest at the rate of 9 percent per year from the 30th day after receipt of due proof to the date of late payment

PAYMENT OF BENEFITS. All benefits will be paid to the Insured or the Insured's Designee.

PAYMENT OF CLAIMS. If an Insured dies while dental insurance benefits, if any, are unpaid, we may, at our option, pay the person or institution on whose charges claim is based, any member of the Insured's immediate family or the Insured's estate.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PHYSICIAN-PATIENT RELATIONSHIP. The Insured will have free choice of any physician practicing legally. We will in no way disturb the physician-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. We cannot contest the validity of the policy after one year from the date of issue except for non-payment of premiums. We cannot contest an Insured's insurability after his or her insurance has been in force for one year while the Insured is alive. Any of the insured's statements that we contest must be in written application signed by the Insured.

WORKER'S COMPENSATION. The policy does not satisfy any requirements for coverage of worker's compensation insurance.

GRACE PERIOD. The policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force. If the Policyholder has not sent us a written request to terminate the policy and a premium is not paid by the end of the grace period, the policy will terminate at the end of the grace period. If the Policyholder gives us written notice of termination before the premium due date, the policy will be terminated as of the date requested. The Policyholder will be liable for any unpaid premium for the time the policy was in force, including the grace period.

COORDINATION OF BENEFITS

STATEMENT OF ERISA RIGHTS

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

1. Receive Information About Your Plan and Benefits

a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

3. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $1 10 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

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

A Claims Filing PROCEDURES

Written notice of claim must be furnished to Companion Life Insurance Company, 7909 Parklane Road, Suite 200, Columbia, SC 29223-5666, within twenty (20) days after the event on which the claim is based, or as soon thereafter as is reasonably possible. Notice of claim should include the Employer’s name, Insured’s name, and Employer’s Group Number. Failure to give notice within the time does not invalidate nor reduce any claim if the claimant can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably

possible. Upon receipt of the notice, Companion Life will furnish or cause a claim form to be furnished to the claimant. If the claim form is not furnished within fifteen (15) days after Companion Life receives the notice, the claimant will be deemed to have complied with our proof of loss requirements. The claimant must submit written proof covering the nature and extent of the claim within the policy time limit for filing proof of loss.

PROOF OF CLAIM

Companion Life must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Insured Employee shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. In any event, except in the absence of legal capacity, claims must be filed by the end of the calendar year after the calendar year in which the loss occurred or the claim will be denied.

Receipt of a claim by Companion Life will be deemed written proof of loss and will serve as written authorization from the Insured Employee to Companion Life to obtain any medical or financial records and documents useful to Companion Life. Companion Life, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to Companion Life in support of an Insured's claim will be deemed to be acting as the agent of the Insured Employee.

There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims, and Concurrent Care Claims. Companion Life will make a determination for each type of claim within the following time periods:

a Pre-Service Claim.

i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.

ii. If a Pre-service Claim is improperly filed, or otherwise does not follow applicable procedures, the Insured Employee will be sent notification within five (5) days of receipt of the claim.

iii. An extension of fifteen (15) days is permitted if Companion Life determines that, for reasons beyond the control of Companion Life, an extension is necessary. If an extension is necessary, Companion Life will notify the Insured Employee within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension, and the date Companion Life expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Insured Employee will have at least forty-five (45) days to provide the required information. If Companion Life does not receive the required information within the forty-five (45) day time period, the claim will be denied. Companion Life will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information.

b Urgent Care Claim.

i. A determination will be sent to the Insured Employee in writing or in electronic form as soon as possible taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.

ii. If the Insured Employee's Urgent Care Claim is determined to be incomplete, the Insured Employee will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Insured Employee will then have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.

iii. If the Insured Employee requests an extension of Urgent Care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Insured Employee will be notified within twenty-four (24) hours of receipt of the request for an extension.

c Post-Service Claim.

i. A determination will be sent within a reasonable time period, but no later than thirty (30) days from receipt of the claim.

ii. An extension of fifteen (15) days may be necessary if Companion Life determines that, for reasons beyond the control of Companion Life, an extension is necessary. If an extension is necessary, Companion Life will notify the Insured Employee within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension, and the date Companion Life expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Insured Employee will have at least forty-five (45) days to provide the required information. If Companion Life does not receive the required information within the forty-five (45) day time period, the claim will be denied. Companion Life will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information.

d. Concurrent Care Claim.

The Insured Employee will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow the Insured Employee time to appeal the decision before the Benefits are reduced or terminated.

Notice of Determination.

a. If the Insured Employee's claim is filed properly, and the claim is in part or wholly denied, the Insured Employee will receive notice of an Adverse Benefit Determination that will:

i. State the specific reason(s) for the Adverse Benefit Determination;

ii. Reference the specific Plan of Benefits provisions on which the determination is based;

iii. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;

iv. Describe the claims review procedures and the Plan of Benefits and the time limits applicable to such procedures, including a statement of the Insured Employee's right to bring a civil action under section 502(a) of ER ISA following an Adverse Benefit Determination on review;

v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request); and,

vi. If the reason for denial is based on a lack of Medical Necessity or Investigational or Experimental Services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

b. The Insured Employee will also receive a notice if the claim is approved.

B. Appeal procedures for an ADVERSE BENEFIT DETERMINATION

1. Insured Employee has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:

a. An appeal must be in writing; and,

b. An appeal must be sent (via U.S. mail) to Companion Life Insurance Company at the address on the Insured's Identification Card; and,

c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,

d. An appeal must include the Insured's name, address, social security number and any other information, documentation or materials that support the Insured's appeal.

2. The Insured Employee will have the opportunity to submit written comments, documents, or other information in support of the appeal, and will have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.

3. If the appealed claim involves an exercise of medical judgment, Companion Life will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.

4. Companion Life will make a final decision on the appeal within the time periods specified below:

a. Pre-Service Claim.

Companion Life will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than fifteen (15) days after receipt of the appeal. If the Insured Employee disagrees with Companion Life's decision, the Insured Employee can submit a second appeal within ninety (90) days after receipt of the final decision of the first appeal. Companion Life will decide the second appeal within a reasonable period of time, taking into account the medical circumstances, but no later than fifteen (15) days after receipt of the second appeal.

b. Urgent Care Claim.

The Insured Employee may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and Companion Life will communicate with the Insured Employee by telephone or facsimile. Companion Life will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the Request for an expedited appeal.

c. Post-Service Claim.

Companion Life will decide the appeal within a reasonable period of time, but no later than thirty (30) days after receipt of the appeal. If the Insured Employee disagrees with Companion Life's decision, the Insured Employee can submit a second appeal within ninety (90) days after receipt of the final decision of the first appeal. Companion Life will decide the second appeal within a reasonable period of time, but no later than thirty (30) days after receipt of the second appeal.

d. Concurrent Care Claim.

Companion Life will decide the appeal of Concurrent Care Claims within the time frames set forth in (B)(4)(a-c) depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

Notice of Appeals Determination.

a. If an Insured Employee's appeal is denied in whole or in part, the Insured Employee will receive notice of an Adverse Benefit Determination that will:

i State specific reason(s) for the Adverse Benefit Determination;

ii.. Reference specific provision(s) of the Plan of Benefits on which the benefit determination is based;

iii. State that the Insured Employee is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;

iv. Describe any voluntary appeal procedures offered by Companion Life and the Insured Employee's right to obtain such information;

v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or

state that such information will be provided free of charge upon request);

vi. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental Services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request); and

vii. Include a statement regarding the Insured Employee's right to bring an action under section 502(a) of ERISA.

b. The Insured Employee will also receive a notice if the claim on appeal is approved.

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW AND NOTICE CONCERNING COVERAGE LIMITS AND EXCLUSIONS

Issued by:

COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200
COLUMBIA, SOUTH CAROLINA 29223-5666
P.O. BOX 100102, COLUMBIA SC 29202-3102
(803) 735-1251

ILLINOIS LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION LAW

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its policy obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

DISCLAIMER

The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

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The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

Illinois Life and Health Insurance Guaranty Association
8420 West Bryn Mawr Avenue
Chicago, Illinois 60631
(312) 714-8050

Illinois Department of Insurance
320 West Washington Street
4th Floor
Springfield, Illinois 62767
(217) 782-4515

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Summary of General Purposes and
Current Limitations of Coverage

The Illinois law that provides for this safety-net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law") [215 ILCS 5/531.01, et seq.]. The following contains a brief summary of the Law's coverages, exclusions and limits. This summary does not coverage all provisions, nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

A) Coverage:

The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:

- life insurance, health insurance, and annuity contracts;
- life, health or annuity certificates under direct group policies or contracts;
- unallocated annuity contracts; and
- contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities. The beneficiaries, payees, or assignees of such persons are also protected, even if they live in another state.

B) Exclusions from Coverage:

The Guaranty Association does not provide coverage for:

- any policy or portion of a policy for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate guarantees which exceed certain statutory limitations;
- certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery;
- any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
- any stop loss insurance.

In addition, persons are not protected by the Guaranty Association if:

- the Illinois Director of Insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or their policy was issued by an organization which is not a member insurer of the Association.

Limits on Amount of Coverage:

1) The Law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty Association's liability is limited to the lesser of either:
   a) the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or
   b) with respect to any one life, regardless of the number of policies, contracts, or certificates:
      i) in the case of life insurance, $300,000 in death benefits but not more than $1 00,00 in net cash surrender or withdrawal values;
      ii) in the case of health insurance, $300,000 in health insurance benefits, including net cash surrender or withdrawal values; and
      iii) with respect to annuities, $100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and $100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is $5,000,000 in benefits per contractholder, regardless of the number of contracts.

2) However, in no event is the Guaranty Association liable for more than $300,000 with respect to any one individual.

NOTICE OF PRIVACY PRACTICES
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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Privacy Promise

We will keep your medical information private. We will also give you this notice about our privacy practices, our legal duties and your rights concerning your medical information. We will follow the privacy practices that we describe in this notice while it is in effect. This notice takes effect April 14, 2003. It will remain in effect until it is changed or replaced.
We reserve the right to change our privacy practices and the terms of this notice at any time, as long as the law allows it. We reserve the right to make these changes effective for all medical information that we keep, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to you at the time of the change.
You may request a copy of our notice at any time or see a copy on our Web site at www.CompanionLife.com.

Uses and Disclosures of Medical Information
We may use and disclose medical information about you for treatment, payment and healthcare operations. For example: Treatment: We may use and disclose your medical information to a physician or other healthcare professional so they can treat you.

Payment: We may use and disclose your medical information for these and other related activities:

- to pay claims from physicians, hospitals and other healthcare professionals for services you received that your dental plan covers
- to determine your eligibility for benefits
- to coordinate those benefits
- to determine medical necessity
- to obtain premiums
- to issue explanations of benefits to the subscriber

We may disclose your medical information to a healthcare professional or entity also bound by the federal Privacy Rules so they can obtain payment or engage in payment activities.

Health Care Operations: We may use and disclose your medical information in the normal course of our health care operations. This includes:

- determining our risk and premiums for your dental plan
- quality assessment and improvement activities
- reviewing the qualifications of dental care professionals; evaluating practitioner and provider performance; conducting training programs, accreditation, certification, licensing or credentialing activities
- medical review, legal services and auditing, including fraud and abuse detection and compliance
- business planning and development
- business management and general administrative activities, including management activities relating to privacy, customer service, resolving internal grievances, and creating de-identified information or a limited data set.

We may disclose your medical information to another entity that has a relationship with you and is also bound by the federal Privacy Rules, for their healthcare operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, or detecting or preventing healthcare fraud and abuse.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. You may revoke your authorization in writing at any time. This will not affect any uses and disclosures that your authorization allowed while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any reason except those described in this notice.

Your Family and Friends: We may disclose your medical information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. We may use or disclose your name, location, and general condition or death to notify, or help notify (including identifying or locating) a person involved in your care.

Before we disclose your medical information to that person, we will give you a chance to object to us doing so. If you are not available, or if you are incapacitated or in an emergency situation, we will disclose your medical information based on our professional judgment of what we think would be in your best interest.

Your Employer or Organization Sponsoring Your Group Dental Plan: We may disclose your medical information and that of others in your group dental plan to the employer or other organization that sponsors it so they can administer the

plan. Please see your group dental plan document for a full explanation of the uses and disclosures that the plan sponsor may make of your medical information in providing plan administration.

We may disclose summary information about those in your group dental plan to the plan sponsor for two reasons. One is to get premium bids for the dental insurance coverage offered through your group dental plan. The second is to decide whether to modify, amend or terminate your group dental plan. The summary information we may disclose summarizes claims history, claims expenses or types of claims those in your group dental plan have filed. The summary information will not include demographic information about the people in the group dental plan, but the plan sponsor may be able to identify you or others from the summary information.

Underwriting: We may receive your medical information for underwriting, premium rating or other activities we do to create, renew or replace a contract of dental insurance or dental benefits. We will not use or further disclose this medical information for any other purpose, except as required by law, unless the contract of dental insurance or dental benefits is placed with us. In that case, our use and disclosure of your medical information will be as described in this notice.
Disaster Relief: We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes that are in the public interest or benefit:

- as required by law
- for public health activities. These include disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury.
- to report adult abuse, neglect or domestic violence
- to health oversight agencies
- in response to court and administrative orders and other lawful processes
- to law enforcement officials in response to subpoenas and other lawful processes concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and to identify or locate a suspect or other person
- to coroners, medical examiners and funeral directors
- to organ procurement organizations
- to avert a serious threat to health or safety
- in connection with certain research activities
- to the military and to federal officials for lawful intelligence, counterintelligence and national security activities
- to correction institutions regarding inmates
- as authorized by state workers' compensation laws.

Health-Related Services. We may use your medical information to contact you about health-related benefits and services or about treatment alternatives. We may disclose your medical information to a business associate to assist us in these activities.

Marketing. We may use or disclose your medical information to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts.
Individual Rights

Access: You have the right to look at or get copies of your medical information, with some exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical to do so. To get your medical information, you must make a request in writing. You may obtain a form to request access by using the contact information listed at the end of this notice. If you request copies, we will charge you $0.50 for each page and for staff time to copy your medical information. We also will charge for postage if you want us to mail the copies to you. If you request another format, we will charge a cost-based fee for providing your medical information in that format. Contact us using the information listed at the end of this notice for a full explanation of our fees.

Disclosure Accounting: You have the right to request in writing to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, healthcare operations, as authorized by you, and for certain other activities, on or after April 14, 2003. We will give you the date on which we made the disclosure, the name of the person or entity to whom we disclosed your medical information, a description of the medical information we disclosed, the reason for the disclosure, and certain other information. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to

these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fees.

Restriction: You have the right to request in writing that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions must be in writing signed by a person authorized to make such an agreement for us. We will not be bound unless our agreement is in writing.

Confidential Communications: You have the right to request that we communicate with you about your medical information by other means or to other locations. You must make your request in writing. You must state that the information could endanger you if we do not communicate to you in confidence as you request. We must accommodate your request if it is reasonable, if it specifies the other means or location, and if it permits us to continue to collect premiums and pay claims under your dental plan. This includes sending explanations of benefits to the subscriber of your dental plan.

Even though you requested that we communicate with you about that dental care in confidence, an explanation of benefits issued to the named insured for dental care that you received (for which you did not request confidential communications), or about the named insured or others covered by the dental plan in which you participate, may contain sufficient information, such as deductible and out-of-pocket amounts, to reveal that you obtained dental care for which we paid.
We will not be bound to your confidential communications request unless our agreement is in writing.

Amendment: You have the right to request that we amend your medical information. Your request must be in writing. It must explain why we should amend the information. We may deny your request if we did not create the information you want amended and the person or entity that did create it is available or we may deny your request for certain other reasons. If we deny your request, we will send you a written explanation. You may respond with a statement of disagreement that we will add to the information you wanted to amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
Electronic Notice: If you receive this notice on our Web site or by electronic mail (e-mail), you may request this notice in written form. Please contact us using the information listed at the end of this notice to request this notice in written form.

Questions and Complaints
If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about your privacy rights, you may tell us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We can give you that address upon request.
We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer: Bruce Honeycutt
Address: AZ-300, I-20 @ Alpine Road
Columbia, SC 29219
Telephone: (803) 264-3435 Fax: (803) 264-7257