PARAMOUNT DENTAL

Affiliate of ProMedica

Paramount Dental Health Insurance
Exchange Dental Offerings

Oral health is an integral piece of overall health and Paramount Dental seeks to drive healthier outcomes. We have offered dental plans for more than 32 years. Our plans offer comprehensive coverage that encourage better oral hygiene and access to care.

- National network of dental and vision providers
- 3,400 proprietary in-network dentists
- 90,000+ dentists nationwide through our leased network
- No missing tooth exclusions
- No pre-existing conditions

Insurance products are marketed by Health Resources Inc (dba Paramount Dental) and underwritten and administered by Paramount Insurance Company dba Paramount Dental.

This Policy, along with Your Summary of Dental Plan Benefits, describes the specific benefits of Your Paramount Dental Plan and how to use them.

Visit **Paramount Dental** Online 24 hours a day/7 days a week at **InsuringSmiles.com**

Contact Member Services
Paramount Dental
(7:00 am – 7:00 pm CST Monday through Friday) 800.727.1444
P.O. Box 659, Evansville, IN 47704-0659

DENTAL ONLY POLICY

Table of Contents

Note: Please read this Policy together with the Summary of Dental Plan Benefits. The Summary of Dental Plan Benefits lists the specific provisions of Your Policy. If a statement in the Summary of Dental Plan Benefits conflicts with a statement in this Policy, You should ignore the conflicting statement in the Summary of Dental Plan Benefits.

Paramount Dental Policy

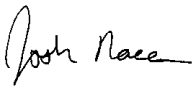
Thank You for enrolling in Paramount Dental! Oral health is a vital part of overall health, and it is Our pleasure to be included in Your wellness plan. Paramount Dental collaborates with the dental profession to design dental plans that promote oral health care along the most cost-effective path. As any dental care professional will attest, the key to avoiding costly dental problems is prevention.

You have a wide choice of Network Dentists, both generalists and specialists, nationwide! Network Dentists submit Claim Forms for services performed for You and payments are paid directly to them. Network Dentists also sign contracts with Paramount Dental to accept certain agreed upon fees, therefore, You may realize significant savings.

Paramount Dental is also committed to providing the highest quality Member services to all Members. Our dedicated team is available toll-free, Monday through Friday. You may also access information through Our website, InsuringSmiles.com. It is Your responsibility to be informed about Your Benefits and any associated Limitations and Restrictions, so please read and save this policy for reference.

Our mission is to offer dental plans that "Improve Your Health and Well-Being." Since 1986, that is exactly what We have delivered to Our Members. We look forward to continuing that promise to Our customers.

Sincerely,



President

This Policy is a legal document (a contract) between Paramount Dental (referred to as We, Us, Our, Paramount Dental, or the Company) and You (referred to as You, Your, or the Member). It is to provide Benefits to You and is subject to the terms, conditions, Limitations and Exclusions stated herein.

Paramount Dental issues based on Your benefit choices and payment of the required Policy. The Policy includes:

- The Summary of Dental Plan Benefits;
- Your application;
- Any riders; and
- Any amendments.

Definitions

Adverse Benefit Determination: Any denial, reduction or termination, or a failure to provide or to make payment (in whole or part) of the Benefit sought.

Balance Billing: Network Dentists agree to accept the Network's contracted fees as payment in full. A participating Network Dentist has agreed to not bill the patient for the difference between their Fee Charged and the contracted maximum allowable fee. This is referred to as "Balance Billing."

Benefits: The amounts that the Policy pays for Covered Services under Your dental Policy.

Benefit Plan Year: The plan year. (See the Summary of Dental Plan Benefits for Your Benefit Plan Year.)

Children or Child: Your natural Children, step Children, adopted Children, Children by virtue of legal guardianship, or Children who are residing with You during the Waiting Period for adoption or legal guardianship.

Claim/Claim Form: Standard statement of dental services performed that is Submitted by You or Your Dentist to request payment from the Payor. Network Dentists always file Claim Forms on behalf of Members and accept payment directly from the Payor. Claim Forms are also used to request a Pre-Treatment Estimate.

Completion Dates: The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;
- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Copayment / Coinsurance: The Member's share, expressed as a fixed percentage, of the covered dental service.

Covered Services: Dental care services for which a reimbursement is available under a Member's Policy, or for which a reimbursement would be available but for the application of contractual Limitations such as Deductibles, Copayments, Coinsurance, Waiting Periods, annual or Lifetime Maximums, frequency Limitations, alternative Benefit payments, or any other Limitation.

Deductible: The amount a person and/or a family must pay toward Covered Services before Paramount Dental begins paying for those services under this Policy. The Summary of Dental Plan Benefits lists the Deductible that applies to You, if any.

Deny/Denied: If a service is Denied, the service is not considered a Benefit of the patient's coverage and the allowable amount is collectible from the patient.

Dentist: Dental care provider who is skilled in and licensed to practice the prevention, diagnosis, and

treatment of diseases, injuries, and malformations of the teeth, jaws, and mouth and who makes and inserts false teeth.

Dependent/Dependent Child: Any member of Your family who meets all the applicable Eligibility requirements, has been enrolled in the Policy and for whom the payment required has been received by Paramount Dental. Dependent Child may include Your biological child, stepchildren, adopted children, foster children, children subject to legal court or administrative order to provide health coverage. Coverage for adopted children is effective upon the earlier of the date of placement or the date of entry of an order granting custody.

Disallow(ed): If a service is disallowed, the fee is not collectible from the patient by a Network Dentist or the Policy.

Effective Date: The date this dental policy begins. The Effective Date is determined in accordance with Waiting Periods.

Eligible Persons: Eligible Persons include Your legal spouses, as defined by state and federal law, and Dependents. Dependent Children are eligible until they reach age 26. Dependent Child may include Your biological Children, step Children, adopted Children, foster Children, Children subject to legal guardianship, newborn Children, or any Child for whom You are the legal guardian or are required by a court or administrative order to provide dental coverage. Coverage for adopted Children is effective upon the earlier of: the date of placement or the date of entry of an order granting custody.

Exclusions: Services that are not covered under this Policy.

Explanation of Benefits (EOB): The statement received after a Claim is processed, detailing how Your Claim was processed, including identification of services rendered, fees, application of Policy Limitations, calculation of Policy payment, and the amount for which You are responsible.

Fee Charged: The amount that the Dentist bills and is entered on a Claim as the charge for a specific service.

Lifetime Maximum: The cumulative dollar amount that a Policy will pay for dental care incurred by an individual Member for the life of the Member. Lifetime Maximums usually apply to specific services such as orthodontic treatment.

Limitations: A list of conditions or circumstances that limit or exclude services from this Policy. Limitations may be related to time or frequency (the number of services permitted during a stated period).

Maximum Allowable Amount: The maximum amount of reimbursement this Policy will pay for covered dental services provided by a Dentist to a Member and which meets Our definitions of a Covered Service. The maximum allowable/expense is determined by: a) the lesser fee of the primary or secondary insurance carrier as it applies to Network participation, associated agreed discounts and Patient Responsibility or b) the fee considered for the global service. For Network Dentists, this is the dollar amount that the attending Dentist has agreed to accept as payment in full for the Policy and the patient. This amount is shown on the notice that accompanies payment of the Claim.

Maximum Out of Pocket: The maximum amount you will have to pay for covered services within your plan year. After reaching this amount on deductibles, copayments, and coinsurance for in-network services, the Plan will then pay 100% of the costs for covered benefits.

Policy Annual Maximum Benefit: The total maximum dollar amount this Policy will pay toward the cost of dental care incurred by an individual Member in a Plan Year.

Medically Necessary Orthodontic: Pediatric (under 19) orthodontic services with significant impairment as a result of craniofacial abnormalities, malocculsions caused by trauma, or congenital disharmonies that affect daily ability to function, like speaking and eating.

Member: A person covered under this Policy.

Network Dentist: A Dentist who contracts with Paramount Dental or leased Network carrier and agrees to accept contracted fees as payment in full and abide by certain administrative guidelines.

Network: A panel of Dentists that contractually agree to provide treatment according to administrative guidelines, including limits to the fees accepted as payment in full.

Out-of-Network Dentist: A Dentist who does not contract with Paramount Dental to participate in the Network and the associated administrative guidelines including Claim submission requirements and maximum allowable fee capitations.

Patient Responsibility: The portion of a Dentist's fee that a Member must pay for dental services, including Deductible, Coinsurance, any amount over Policy maximums, services the Policy does not cover and Covered Services for which the patient is not eligible.

Pre-Authorization: A requirement that recommended treatment must first be approved by the Policy before the treatment is rendered in order for the Policy to pay Benefits for those Covered Services.

Premiums: The money billed and paid to Paramount Dental for each month of dental coverage.

Pre-Treatment Estimate: A non-binding estimate of the Benefits available and Patient Responsibility for a proposed treatment plan after the application of Policy Limitations, restrictions, and Exclusions, remaining Plan Annual Maximum and determination of Covered Services.

Resin/Composite: Tooth-colored filling material. Although cosmetically superior, it is less durable than other materials.

Submitted/Billed Amount: The amount a Dentist bills to Paramount Dental for a specific treatment or service. A Participating Dentist cannot charge You or Your Eligible Dependents for the difference between this amount and the amount Paramount Dental approves for the treatment.

Summary of Dental Plan Benefits: A description of the specific provisions of Your coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Policy. This Policy supersedes any contrary provision of the Summary of Dental Plan Benefits.

Waiting Period for Policy Eligibility and For Covered Services: The stated period of time that a Member must be enrolled in the Policy before being eligible for Benefits or for a specific category of Benefits. A Waiting Period limits reimbursement for various services until the insured has been covered for a specific amount of time. Waiting Period can also apply to specific/individual procedures.

Eligibility/Eligibles

Paramount Dental is available to You and Your Dependents. Coverage provided under the Policy shall be in accordance with the Eligibility, Effective Date, and Termination provisions of the Policy, including any coverage classifications.

Extended Coverage for a Dependent Child

If You have Dependent(s) with a permanent mental, intellectual, or physical disability to the extent they cannot support themselves, they qualify for coverage beyond the applicable age limit for Dependent(s).

To request special enrollment or obtain more information, contact Paramount Dental Member services.

Eligibility Through The Marketplace

To be eligible to enroll in this plan through the Marketplace, You and Your Dependents must meet the three following requirements:

1. Must be a U.S. Citizen, U.S. National, or a lawfully present non-citizen;
2. Cannot be incarcerated (in prison; does not apply if you are awaiting disposition of charges; and
3. Must reside in a Paramount Dental Service Area.

An applicant who meets these three requirements is considered a qualified individual (QI) and is eligible for coverage through the Marketplace. A QI may only enroll through the Marketplace during the annual open enrollment period or a special enrollment period. Special Enrollment Periods are provided when a QI or Dependent experiences a qualifying event.

Enrollment Periods

Initial Enrollment

At the time You enroll, You are given a coverage Effective Date.

Annual Open Enrollment Period

Annual open enrollment period is the time each year when You can newly enroll in a plan or change to a different plan.

Special Enrollment Periods

Certain qualifying events throughout the year can trigger a special enrollment period (SEP). A SEP may enable you to newly enroll in a plan or change to a different plan within the same level of overage outside of annual open enrollment. If you are declining enrollment for your Dependent(s) (including your spouse) and a dependent experiences a qualifying event, you may be able to enroll your Dependent in this plan provided that you request enrollment within 60 days of a qualifying event.

Special Enrollment Period (SEP) Qualifying Event Categories

You may qualify for a SEP to enroll in or change plans outside of annual open enrollment if you experience a qualifying event in one (1) of the following categories:

1. Loss of qualifying coverage
    a. Loss of Minimum Essential Coverage (MEC) as defined by criteria of the Affordable Care Act requirement for having coverage
    b. Loss of MEC may include but not be limited to; losing job-based coverage, losing marketplace plan coverage, losing coverage through family member, etc. Please refer to https://www.healthcare.gov for full listing of loss of MEC.
2. Change in household
    a. Marriage;
    b. Birth, adoption, placement for adoption or foster care;

c. Legal separation or divorce; or
d. Death of Member or Dependent

3. Change in residence
    a. Permanent move of a Member or Dependent
4. Other qualifying changes
    a. Termination of Medicaid or Children's Health Insurance Program (CHIP) coverage

Web Services

Paramount Dental offers information and various services on its website. The website is continually revised, improved and enhanced for Your convenience. Members may:

- Find a Network Dentist,
- Verify Benefit plan, renewal dates, Dependent coverage, Claim status,
- Print Member Cards,
- Review Benefit history,
- Download brochures, and
- Acquire oral health and wellness tips.

Online materials serve as the primary source of information for Members, Dentists and advisers. Any printed documents that You may have is based on information at a certain point in time and may not be inclusive of all Benefits, restrictions and Limitations. All documents may also be requested by contacting Our Customer Service Center at: 1-800-727-1444.

Member ID CARD

A Paramount Dental Member ID Card will be issued to You upon effectuation.

Selecting a Dentist – Receiving Dental Care

Dentistry is a highly personal service. You may have any dental treatment performed as decided by You and Your Dentist. The Policy does not dictate what treatment You receive. Only You and Your Dentist can determine that. However, the Policy does determine what services are covered. The Policy coverage selected by You pays for only those Covered Services under Your Paramount Dental Policy listed in this Policy within the Limitations and restrictions presented. You must personally pay for any service which is not covered or for any service that is covered but is subject to Limitations and restrictions. The Policy will only cover services for In-Network Dentists. Your Claim will only be processed after completion of the dental service. If You are not sure whether a particular dental treatment is covered or how much You will be required to pay, You may request a Pre-Treatment Estimate from Your Dentist. It is a free service offered by Paramount Dental.

Some services are limited by the age of the patient, by how often the service may be performed, or by specific teeth. All time intervals (frequency Limitations) required by coverage are independent of calendar year or plan year. Frequency Limitations regarding how often services may be performed are continuous. Change of dental plan coverage, termination and reinstatement of coverage does not eliminate the frequency Limitations.

Paramount Dental also offers a large, nationwide, Network of credentialed Dentists to accommodate oral health needs of You and Your family. Simply visit the Find a Dentist link on InsuringSmiles.com, to view a complete listing of general and specialty Network Dentists in Your geographical area. The Network listing generated from the website includes access to all Paramount Dental and leased Networks included in Your Policy. Network Dentists provide the same excellent service at a contracted fee, resulting in savings for You and Your family.

You should always verify the Policy and Your Summary of Dental Plan Benefits prior to Your dental visit as it makes a difference in Your Coinsurance and savings. Network Dentists are independent contractors and are not Paramount Dental employees.

Benefit Categories – What is Covered by My Policy?

Important - It is very important to understand that You have selected which services are included in Your Policy. Please review both this Policy and the Summary of Dental Plan Benefits carefully. **ONLY the dental services listed in Your Summary of Dental Plan Benefits will be covered by Your Policy.** The Summary of Dental Plan Benefits is part of this Policy.

Covered Services are also subject to Exclusions and Limitations and are included in a later section of this Policy.

The various dental services provided by a Dentist are classified into six service categories:

1. Diagnostic and Preventive Services
2. Basic Services
3. Major Services
4. Adjunctive/Other Services
5. Orthodontic Services

Diagnostic and Preventive Services
These services are important to Your overall oral health and the detection and prevention of dental disease. They include examinations and evaluations (routine and problem focused), prophylaxes (routine teeth cleanings), radiographs (x-rays), fluoride treatments, and sealants and space maintainers (for Children).

Basic Services
Basic services include a variety of specialized services.

- Minor Restorative Services – these procedures rebuild and repair Your teeth damaged by disease,

decay, fracture or injury. Both amalgam (silver) and Composite (white tooth colored) fillings on baby and adult teeth and anterior and posterior teeth are considered in this category.

- Endodontic Services – these procedures treat teeth with diseased or damaged nerves. Root canals are included in this category.
- Non-surgical Periodontics Services – these procedures involve the treatment of diseases of the gums and supporting structures of the teeth. Non-surgical procedures include periodontal scaling and root planning, full mouth debridement and periodontal maintenance following a periodontal therapy (periodontal cleanings). Periodontal procedures that are surgical in nature are considered major procedures.
- Simple Extractions – this procedure is an extraction of a tooth that is erupted or exposed root.
- Relines and Repairs – these procedures reline and repair existing dentures (partial and complete) and repair existing bridges.

Major Services
Major services typically involve major restorative procedures, surgical procedures and services that replace missing natural teeth, such as bridges, partial dentures, and complete dentures.

- Major Restorative Services – these services include crowns. Crowns may be covering a natural tooth or an implant.
- Surgical Periodontal Services – osseous surgery and gingivectomy are considered major services.
- Oral Surgery Services – surgical extractions of tooth/teeth are included in this category and include the removal of impacted teeth and other extractions including removal of bone. An incisional biopsy of oral tissue for the detection of cancer or other suspected disease is also included in oral surgery services.
- Prosthodontic Services – bridges, partial dentures and complete dentures are in this category.
- Implant Services – the placement of an endosteal implant and the associated abutment.

Adjunctive/Other Services
Your Summary of Dental Plan Benefits will list any other Benefits that You have selected.

Orthodontic Services
Medically Necessary Orthodontic services that may be covered include traditional braces, clear orthodontic treatment (aligners) and removable appliances. Retainers are considered part of the orthodontic treatment.

How Payment is Made for These Benefits Categories
When filing Claims, Your dental office will use the appropriate dental code(s) found in the American Dental Association's current Code on Dental Procedures and Nomenclature (CDT). The codes are too numerous to list, however the staff at Your dental office is well versed in using these codes and the staff can explain them more thoroughly at Your request.

It is best, though not necessary, to have Your Dentist file a pretreatment estimate for services totaling over $300 to fully identify what Benefits are available to You. This will avoid any confusion as to the balance You may owe Your Dentist. Not all plans cover the same procedures, and if there is any doubt to the coverage of Your Policy a representative of Paramount Dental would be glad to go over it with You. Your Dentist also has access to Your specific coverage and can review it with You.

Copayment / Coinsurance

Covered Services and the percentage of covered expense provided by the Policy and Limitations to Covered Services are indicated on Summary of Dental Plan Benefits. The percentage of Policy payment (co-insurance) is valid only for services obtained from participating Network Dentists contracted with Paramount Dental or a leased Network. A participating Network Dentist has agreed to not bill, otherwise known as "Balance Billing," the patient for the difference between his Fee Charged and the contracted maximum allowable fee.

Policy Features

This list of Policy features describes the features that are available through Paramount Dental but may not be included in the coverage that You have selected. To see a list of Policy features that are specific to Your Benefit coverage, please refer directly to Summary of Dental Plan Benefits. If a Policy feature is not listed on Your Summary of Dental Plan Benefits then it is not a part of Your Dental Benefit Policy.

Policy Annual Maximum Benefits/Plan Year

Benefits payable under the Policy, regardless of whether coverage is continuous or not, shall be subject to the Policy Annual Maximum for each plan year. Payments under Your Policy for ALL Covered Services apply to the Policy Annual Maximum Benefit. Change of the dental Policy coverage, termination, and reinstatement of coverage does not eliminate frequency Limitations or Policy Annual Maximum Benefit used. You will continue to receive Network savings on all Covered Services after Your Annual Maximum has been reached.

Deductible

The Policy Year Deductible (if any) is applicable to Covered Services incurred in each Policy Year. Your Policy will determine the Deductible application method You selected. The available methods include:

Out of Pocket Deductible

An out of pocket Deductible is the specified & consistent amount reduced from the Policy's covered expense which must be paid in full by the Member each Policy year. It is applied chronologically according to the dates in which the Covered Services were completed and increases the Patient Responsibility by the specified amount until the earlier of two events 1) individual Deductible is met, or 2) family Deductible is satisfied.

Ex: (Fee Allowed X Co-Insurance) – Deductible = Policy Payment

Patient A receives major services covered at 50% under the Policy. This patient is responsible for a $50 individual Deductible.

Benefit Deductible

A Benefit Deductible is the amount a Member must pay toward Covered Services before the carrier will reimburse for those Covered Services. This amount may vary based upon the co-insurance of the Covered Service.

Ex: (Fee Allowed - Deductible) X Co-Insurance = Policy Payment

Patient B receives major services covered at 50% under the Policy. This patient is responsible for a $25 individual Deductible.

Waiting Period

When a new dental policy is purchased with Paramount Dental, the plan may include a Waiting Period before the dental procedures in that category of services, as shown in the Summary of Dental Plan Benefits, are covered. This period starts on Your Effective Date and will be restarted if You terminate and later reapply for coverage. The one exception is if You have continuous coverage on Your Dental Policy and change Your selected plan. Although You will have a new Effective Date, the Waiting Period time period does not start over. If You were covered under a prior Paramount Dental plan, credit toward meeting the Waiting Period will be given for the time You were covered under the prior Paramount Dental plan.

The Waiting Period does not apply to pediatric dental care.

Alternate Benefits

There is often more than one service that can be used to appropriately treat a dental problem or disease. In determining the Benefits payable on a Claim, different materials and methods of treatment will be considered. If applicable, the amount payable will be limited to the Covered Expense for the least costly Service, which meets broadly accepted standards of dental care as determined by Us. A Member and their Dentist may decide on a more costly service or material than We have determined to be satisfactory for the treatment of the condition. In this case, the Policy will be a Benefit toward the cost of the more expensive service or material, but the payment will be limited to the Benefits payable for Covered Expenses for the least costly Covered Service.

Maximum Out of Pocket

The maximum amount you will have to pay for covered services within your plan year. After reaching this amount on deductibles, copayments, and coinsurance for in-network services, the Plan will then pay 100% of the costs for covered benefits.

Unbundling

When charges for less complicated Services performed in conjunction with the more comprehensive/extensive definitive treatment are separated, these less complicated components may be considered as parts of the primary Service. If the Dentist bills separately for the primary Service and each of its component parts, the total Benefit payable for all related charges will be limited to the Benefits payable for Covered Expenses for the primary Service.

Service Exclusions

Paramount Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for the same will be Your responsibility (though Your payment obligation may be satisfied by insurance or some other arrangement for which You are eligible):

General Exclusions

All Policies issued or administered by Paramount Dental are subject to the following General Exclusions.

This Policy will not pay for:

1. Dental services that are not listed in the Policy Covered Services and Policy General Exclusions, Limitations and Restrictions attached to this Policy.
2. Claims for dental services rendered before the Effective Date or after coverage is terminated.
3. Claims for dental services covered under non-dental insurance.
4. Claims for services performed primarily to rebuild occlusion or for full mouth reconstruction.
5. Claims for Members until Paramount Dental receives the appropriate contracted payment(s) for Premiums.

6. Claims for services which are not completed.
7. For duplicates, lost, or stolen prostheses, appliances, and/or radiographic images.
8. A Claim must be received within one year from the date of service.
9. Space maintainers, except when needed to preserve space resulting from the premature loss of deciduous (baby) teeth and are only applicable to Children under age 19.
10. Orthodontic treatment, unless otherwise specified in Your Summary of Dental Plan Benefits.
11. Treatment of temporomandibular joint or jaw joint disorder (TMJ).
12. Dental services provided by a non-Network participating Dentist.
13. Dental services if Benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.
14. Dental services or charges separately billed by hospitals, laboratories, pharmacies or other institutions other than a Dentist practice.
15. Experimental or investigational dental treatment.
16. Dental services as a result of Your participation in a misdemeanor, felony, riot or insurrection.
17. Dental services charged and filed on a Claim under an unspecified CDT service code X999.
18. Submitted Claims for which Paramount Dental has not received the Dentist documentation (federal W9 form, documentation requirements – radiographs, primary Explanation of Benefits, etc., or unable to process due to incorrect filing information) required to determine and finalize the Claim Benefit.

Service Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for the services or supplies that exceed these Limitations will be Your responsibility. All time Limitations are measured from the applicable prior dates of services in Our records with any Paramount Dental Policy:

Diagnostic Evaluations and Treatments

Evaluations (examinations), including any and all procedure codes, are payable twice within any Benefit Plan Year. These include all examinations and evaluations performed by any general Dentist or specialist.

A comprehensive oral evaluation or a comprehensive periodontal evaluation for a new or established patient is payable only once every 4 years.

Diagnostic Imaging, Tests, and Examinations

The maximum amount considered for all radiographic images (also referred to as X-rays) taken on one day will be equivalent to an allowance of a full mouth X-ray. The difference may not be billed to the Member.

Panoramic (including image capture only) or full mouth X-rays are payable once every 4 years. If a full mouth X-ray is performed within 12 months of any bitewing image(s), the allowable amount for the full mouth X-ray will be reduced by the charges for bitewing(s). Panoramic or full mouth X-rays will not be payable if performed within 12 months of a set of vertical bitewings images.

Periapical images (including image capture only) are payable up to a maximum of 3 during a 12 month period.

Occlusal images (including image capture only) are payable only once per arch per 12 months.

Bitewing radiographic images (including image capture only) are limited to a maximum of 4 in a 12 month period. Bitewings will not be payable if performed within 12 months of a complete series of images or a set of vertical bitewings images.

2D cephalometric images or 2D oral/facial photographic images (including image capture only) will be payable only if performed in conjunction with a Policy that covers orthodontic services and treatment or Pediatric (under 19). Cephalometric images are payable every 2 years unless image captures only were paid during the same 2 years. 2D oral/facial images are payable every 5 years unless image captures only were paid during the same 5 years.

Diagnostic casts are payable once per 5 years and only if the procedure is performed in conjunction with the Policy's orthodontic Covered Services and treatment or Pediatric (under 19).

Preventive Services:

Prophylaxis: A teeth cleaning (includes prophylaxis, periodontal scalings and root planning, periodontal full mouth debridement and periodontal maintenance) is payable once every 6 months, regardless of the Dentist's specialty. A teeth cleaning for Children under the age of 19 will be payable when filed as a Child's cleaning.

Fluoride: A preventive fluoride treatment is payable once per 6 months.

Sealants: Will be payable on permanent molar teeth (per tooth) only for Children under 19 years of age. A replacement for a sealant will not be payable for a period of 5 years. If a sealant was applied to a tooth, a restoration on the same tooth will not be payable for a period of 3 years.

Space Maintenance: Space maintainers are payable once every 3 years for Children under 19 years of age The re-cementation or re-bonding of a space maintainer is payable only after 12 months after the initial placement and only once per 12 months.

Restorative Services:

A restoration/filling (amalgam or Resin-based Composite) is payable once in any 2 year period per tooth. An additional restoration on the same tooth surface will not be payable for a 2 year period. A restoration will not be payable within years of placing a crown on the same tooth or a sealant on the same surface within 2 years. If two or more restorations are performed on the same tooth, on the same date of service, only the total number of unique surfaces will be considered for payment.

Crowns, or Inlays/Onlays (in any combination including implant supported) are payable once in any 5 year period per tooth. A charge for a crown or an inlay/onlay on a tooth following the placement of an amalgam or Resin-based Composite restoration on the same tooth is not eligible for payment for a period of 5 years. Crowns, other than prefabricated steel crowns, are not payable for primary teeth. Composite/Resin inlays must be laboratory processed.

A Resin-based Composite (indirect) crown is payable on anterior teeth only.

Individual crowns over implants are payable once in a 5 year period.

Not all crowns or inlay/onlays procedure codes are considered covered if a corresponding procedure code using new and advanced materials is determined to be available.

Crowns, inlays/onlays may be subject to review for extensive loss of tooth structure due to caries (decay) or fracture to determine coverage. A Pre-Treatment Estimate is recommended to determine coverage.

A recementation of an inlay, onlay, or crown is payable only once per 12 months and will not be considered for payment if within 12 months of the original cementation.

A protective restoration is payable once every 3 years. Not eligible if performed in conjunction with endodontics, an amalgam/Composite restoration, inlay, onlay, crown, or fixed prosthesis retainer prepared or cemented at the same appointment. Charges for a subsequent definitive treatment are subject to an adjustment if performed within 12 months of a protective restoration…

A core buildup will not be payable if performed within 3 years of restoration and/or replacement within 7 years on the same tooth. Coverage for a core buildup requires the submission of a duplicate, diagnostically acceptable, pre-operative radiographic image or intraoral photo that substantiates one of the following three criteria: 1) more than 50% of the tooth crown is missing due to fracture or decay; 2) less than 3 mm of sound tooth structure remaining around the gum line; 3) previous root canal filling completed except where a prior crown through which the access is made remains on the tooth. Charges not meeting established criteria will be disallowed. A Pre-Treatment Estimate is recommended to determine coverage.

A pin retention is payable per tooth and limited to posterior teeth only. Additional pins will be disallowed.

A post and core in addition to a crown is payable once per 7 years per tooth. A payment is not eligible if performed within 7 years of a core buildup or another post and core. Procedure is not payable without history of root canal therapy.

Endodontics:

All pulpal and endodontic therapy and apexification/ recalcification should be coded by the tooth receiving treatment, not the number of canals per tooth. A single periapical will be considered for payment with an endodontic therapy or an apexification/recalcification only (not pulpal). Separate fees for other radiographs and images are considered part of the treatment plan and will be disallowed. Charges are exclusive of the final restoration charge. Charges for “elective” root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.

Pulpal therapy is not eligible for payment for retreatment within 4 years of the date of the original treatment.

Endodontic therapy is not eligible for payment for retreatment within 4 years of the date of the original treatment.

Apexification/recalcification is limited to Children under 19 years of age and once per lifetime. Not eligible for payment for retreatment within 4 years of the date of the original treatment.

An apicoectomy is payable only once per lifetime.

Non-Surgical and Other Periodontal Services:

Periodontal maintenance is payable once per 6 months for Members over 19 years of age. This procedure will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling and root planning, a scaling in the presence of gingival inflammation, or a full mouth debridement.

A scaling and root planing (4 or more active periodontal diseased and qualified teeth) is payable once in any 3 year period per quadrant. Will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling in the presence of gingival inflammation, a full mouth debridement or periodontal maintenance. The Member must exhibit periodontal disease showing loss of clinical attachment and bone loss. Not payable on deciduous teeth. This procedure

requires the submission of full mouth probe chart with six points per tooth probings AND diagnostic full mouth radiographs and/or vertical bitewings. Only two quadrants are considered on the same date of service, additional quadrants will be disallowed. Separate charges for local anesthetic are disallowed. Charges not meeting established criteria will be disallowed. A pretreatment estimate is recommended to determine coverage. Dental Review Team maintains discretionary authority regarding review requirements.

A scaling in presence of generalized moderate or severe gingival inflammation – full mouth is payable once every 5 years and only for Members under 19 years of age. Will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling and root planning, a full mouth debridement or periodontal maintenance.

A full mouth debridement is payable only for Member under 19 years of age. Procedure is payable once every 3 years and 3 years must lapse between any associated periodontal scalings (scaling and root planning and scaling in the presence of gingival inflammation) were performed. Will not be payable if performed within 6 months of or the same date of service as a prophylaxis, a scaling and root planning or a scaling in the presence of gingival inflammation, or periodontal maintenance.

Periodontal maintenance is payable once per 6 months for Members over 19 years of age. This procedure will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling and root planning, a scaling in the presence of gingival inflammation, or a full mouth debridement.

Periodontic Surgical

The following services are payable only once per area treated within a 5 year period:

- Gingivectomy or gingivoplasty (four or more teeth/tooth per quadrant only)
- Clinical crown lengthening (per tooth)
- Osseous surgery
- Guided tissue regeneration (includes barrier and its removal, as necessary)

Two tissue grafts (of any type, including pedicle soft, autogenous connective, non-autogenous connective, and free soft) are payable once per area treated/quadrant every 5 years. Teeth #24-25 are considered one site.

Prosthodontics:

One upper and one lower denture (including complete, immediate, partial, immediate partial, overdenture and interim) are payable once in any 7 year period. Charges for a conventional, removable partial dentures or a complete denture are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch or of any repairs, relines, rebases. Separate charges for diagnostic casts will be disallowed. An immediate denture will not be payable if used to replace a complete denture.

Fixed partial dentures, including partial denture pontics (non-Resin), partial denture retainers (cast metal and porcelain/ceramic retainers only), and partial denture retainers-crowns (non-Resin) are payable once in a 7 year period. Charges are subject to the same definitions and restrictions as single restoration crowns. Each unit of a fixed partial denture must be identified on the Claim. Not eligible for pontics to replace third molars. All fixed prosthodontic services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. Not eligible for replacement of a removable partial denture by a fixed partial denture within 7 years of the original placement.

Oral Surgery:

Surgical extraction of an erupted tooth requiring removal on bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated, and the removal of residual tooth roots procedures include alveoloplasty. Primary teeth, teeth 7-10 and 23-26 require the submission of a duplicate, diagnostically acceptable, pre-operative periapicial and/or panoramic radiograph with Claim submission. Charges not meeting established criteria will be disallowed.

An exposure of an unerupted tooth or the placement of a device to facilitate the eruption of an impacted tooth will be payable only once per lifetime if the procedure is performed in conjunction with a Policy orthodontic Covered Services and treatment.

An incisional biopsy of soft oral tissue will be disallowed if performed in conjunction with an apicoectomy.

Alveoloplasty in conjunction with routine extractions are subject to review. Charges not meeting generally accepted standards of care will be disallowed.

Incision and drainage of abscess filed in conjunction with definitive treatment will be disallowed.

Excision of pericoronal gingiva filed in conjunction with definitive restorative treatment will be disallowed.

Implant Services

A surgical placement of an implant body (endosteal) or a mini implant is payable once per 7 years per tooth site. Allowance includes the treatment plan, local anesthetic and post-surgical care. Coverage is limited to Members under 19 years of age when Medically Necessary Only.

A prefabricated abutment or a custom fabricated abutment is payable once per 7 years per tooth site. Coverage is limited to Members under 19 years of age

when Medically Necessary Only.

Single crowns and fixed partial denture retainers (abutment or implant supported) will be payable once every 7 years and subject to the same Limitations as non-implant supported single crowns and fixed partial dentures. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.

Adjunctive/Other Services Limitations

Palliative (emergency) treatments will be payable 2 per 12 month period. Charges filed in conjunction with definitive treatment will be disallowed.

Deep sedation/general anesthesia and intravenous moderate (conscious) sedation/analgesia will be payable up to a total of 30 minutes per date of service.

Inhalation of nitrous oxide/analgesia will be payable once per date of service.

Occlusal guards are payable once every 5 years. Charges to modify the appliance or for occlusal adjustment are not payable.

Teledentistry visit is allowable.

Disallowed Services

Participating Dentists may not charge Eligible Persons for disallowed services or supplies. All charges from non-participating Dentists for the disallowed services are Your responsibility.

How Payment Is Made

In-Network Dentists

In-Network Dentists are responsible for submitting Claims to Paramount Dental on Your behalf for rendered services. Paramount Dental will reimburse the In-Network Dentist directly for Covered Services.

A Member is responsible for the Deductible and any out-of-pocket expenses required by the Policy including the co-insurance and the cost of services that are not covered by the Policy. It is possible that Your Dentist charges for one or more of the services may be higher than the maximum allowable under Your Paramount Dental. If so, an In-Network Dentist must reduce the charged amounts. If a Member is billed by an In-Network Dentist for a Covered Service (other than the Deductible, co- insurance, or amount above the maximum allowable fee), the Member should contact either the In-Network Dentist or Paramount Dental.

Filing a Claim

Network Dentists are responsible for submitting Claims to Paramount Dental on Your behalf. All Claims should be Submitted to the Paramount Dental address provided in a separate section of this document. The following information should be included on a standard ADA Claim Form:

a. Members name, address, and identification number (SSN)
b. Patient's name, date of birth, and identification number (SSN)
c. Itemized bill including the ADA code, description of each charge, and date of service
d. Name and address of the Rendering Dentist
e. Rendering Dentist's Tax ID Number (W-9 Form)

Note: To be considered for payment, a Claim must be Submitted within 1 year from the date of service. Some services may require additional information, such as a radiograph image or a periodontal chart before being processed. Benefit payment can only be determined at the time that that Claim is Submitted with all required documentation. Reference the Policy General Exclusions, Limitations, and Restrictions, including provider supporting documentation provision for more information.

Notice of Claim

We must receive written notice within sixty (60) days after a Claim starts or as soon as reasonably possible. Failure to give notice within that time will not invalidate nor reduce any Claim if it can be shown that it was not reasonably possible to give notice at that time, but such notice was given as soon as was reasonably possible. The notice shall be sent to Paramount Dental or given to Our agent.

Claim Forms

Your Dentist will file Your Claim or provide You with the forms necessary to file the Claim. If Your Dentist does not provide these forms within fifteen (15) days, You may send Us a written statement to satisfy this requirement. This statement should include enough information to identify You as well as the nature and extent of the Claim. It should be sent to Us within the time stated in the Proof of Loss provision.

Once Paramount Dental processes Your dental Claim, You will receive an Explanation of Benefits explaining payment amounts. It is possible that Your Dentist's charges for one or more of the procedures may be higher than the maximum allowed under Your Plan. If so, a contracted Network Dentist must reduce the charged amounts.

Proof of Loss

We must receive written proof of loss within ninety (90) days of a Claim. If it is not possible for proof to be provided within the ninety (90) days, We will not Deny a Claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later

than one year from the time specified, unless You are legally incapacitated.

Time of Payment of Claims

Benefits for loss covered by the Policy will be paid when Paramount Dental receives all information necessary, including Premium payment, to correctly adjudicate the Claim, but not more than thirty (30) days after receipt of all necessary information. All benefits will be paid to You, or at your discretion, to Your Provider.

If We fail to pay or Deny a clean Claim in the time required, and We subsequently pay the Claim, We will pay the provider that Submitted the Claim interest on the allowable amount of the Claim.

Legal Actions

A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Right of Recovery

Whenever payments have been made in excess of the amount due under the Policy, Paramount Dental shall have the right, exercisable alone and in its sole discretion, to recover such excess payments from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the Benefits or services provided for the covered person.

Termination of Coverage

Your dental coverage may be automatically terminated: when You fail to pay timely Premium payments or fees to Paramount Dental, subject to the Grace Period.

If any renewal premium is not paid within the time granted for payment, a subsequent acceptance of premium by Us or by an agent authorized by Us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy.

In the event of the death of a Member, unearned premium will be refunded on a pro-rated basis.

Questions and Assistance

Questions regarding Your policy or coverage should be directed to:

Claims Department Paramount Dental.
P.O. Box 659 Evansville, IN 47704-0659
800.727.1444 press 9
(7:00 am – 7:00 pm CST Monday through Friday)

General Conditions and Additional Information

Entire Contract, Changes: The Policy, including endorsements, Summary of Dental Plan Benefits, riders, application and the attached papers, if any, constitute the entire contract of insurance. No change in the Policy will be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. We will consider any statement made by You, in the absence of fraud, as a representation and not a warranty.

We may amend coverage, Limitations to the Covered Services, General Exclusions, Annual Maximum, Benefit payments or any other terms of this Policy upon thirty (30) days written notice to You. This Policy will pay for any Covered Services rendered prior to the Effective Date of the change.

Section titles are for convenience of reference only and are not to be considered in interpreting the Policy. No failure to enforce any provision of the Policy shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of the Policy.

Claims Appeal Procedure

Informal Claims Appeal Procedure

Your Paramount Dental Policy has been carefully designed to provide You with the maximum amount of covered Benefits for Your level of payment/Premium. Since Paramount Dental is always looking for ways to make Our plans even better, Your suggestions are encouraged. Occasionally, even after You have reviewed the applicable sections of this Policy pertaining to Your issue at hand, You may have a question. Your questions may involve Dentists, Covered Services, and the Health Insurance Exchange Marketplace.

Paramount Dental always notifies You or Your authorized representative of a Benefit determination after Your Claim is filed. This notice is made via an Explanation of Benefits (EOB). An Adverse Benefit Determination is any denial, reduction or termination of the Benefit for which You filed a Claim, or a failure to provide or to make payment (in whole or in part) of the Benefit You sought. This includes a determination based on Eligibility, the administration of Covered Services, Limitations or restrictions, and payment amounts. If You receive notice of an Adverse Benefit Determination, and if You think that Paramount Dental incorrectly Denied all or part of Your Claim, You may take the following steps:

First, You or Your Dentist should contact Paramount Dental's Member Services team and ask them to check the Claim to make sure it was correctly processed. If You contact Us in writing, please enclose a copy of Your Explanation of Benefits and describe the problem.

Paramount Dental provides this opportunity for You to describe problems and submit information that might indicate that Your Claim was improperly Denied and allow Paramount Dental to correct this error quickly.

Formal Claims Appeal Procedure

Whether or not You have contacted Paramount Dental informally, as described above, to recheck the initial determination of Your Claim, You or Your authorized representative may submit Your Claim to a formal review through the Claims Appeal Procedure described here. To request a formal appeal of Your Claim, You must send Your request in writing to the Dental Claims Review Team at Paramount Dental. This can be done through the Messaging Center on our website (https://www.insuringsmiles.com/), email (claims@insuringsmiles.com), or fax (812-424-2096).

You must include Your name and address, the Member's ID number, the reason You believe Your Claim was wrongly Denied, and any other information You believe supports Your Claim, including sections of Policy that support Your appeal. If You would like a record of Your request and proof that is was received by Paramount Dental, You should mail it certified mail, return receipt requested. You or Your authorized representative should seek a review as soon as possible after You receive Your EOB; however, You must file Your appeal within ninety (90) days of the date of which You receive Your notice of the Adverse Benefit Determination You are asking Paramount Dental to review.

The Dental Claims Review Team will make their decision and notify You in writing within 30 days of receiving Your request. Their notice of any Adverse Benefit Determination will: (a) inform You of the specific reasons for the denial; (b) list the pertinent Policy provision on which the denial is based; (c) contain a statement that You are entitled to receive upon request and at no cost, reasonable access to and copies of the documents, records and other information relevant to the decision to Deny Your Claim; and (d) contain a statement that You may seek to have Your Claim re-evaluated by the appropriate Department of Insurance in Your state of domicile. You may also have the right to seek to have Your Claim paid by filing a civil action in court.

Notice of Privacy Practices

In compliance with certain applicable laws, the Gramm-Leach-Bliley Act (GLBA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Paramount Dental has adopted these policies. Paramount Dental acknowledges participants' privacy rights as specified in these laws, and has adopted policies and procedures to ensure Your privacy rights are protected.

This Notice describes how nonpublic personal financial information (NPFI) and protected health information (PHI) about You may be used and disclosed and how You can access this information. In this Notice, We explain how We protect the privacy of Your NPFI and PHI, and how We will allow it to be used and given out (disclosed). We are required to provide You with a copy of this Notice of privacy practices upon request. We must follow the privacy practices described in this Notice while it is in effect.

Our Commitment Regarding Your Confidential Information:

We understand the importance of Your NPFI and PHI (hereafter known as Confidential Information), and follow strict policies (in accordance with state and federal privacy laws) to keep Your information private.

Our Privacy Principles:

- We do not sell customer Confidential Information.
- We do not provide customer Confidential Information to persons or organizations outside Paramount Dental and Our business associates for marketing purposes.
- We contractually require any person or organization providing products or services on Our behalf to protect the confidentiality of information We obtain from You.
- We afford prospective and former customers the same protections as existing customers with the respect to the use of Confidential Information.

Your privacy is a high priority for Us and it is treated with the highest degree of respect. We collect and use Confidential Information We believe is necessary to administer Our business and to provide You with customer service. We use Confidential Information to underwrite Your policies, process Your Claims, ensure proper billing, and service Your accounts. We share Confidential Information as necessary to handle Your Claims and to protect You against fraud and unauthorized transactions. However, We want to emphasize that We are committed to maintaining the privacy of this information in accordance with law. All individuals with access to Confidential Information about Our customers are required to follow this policy.

Confidential Information Collected:

- Confidential Information includes demographic data that can reasonably be used to identify You and that relates to Your past, present or future physical or mental health, the provision of health care to You, or the payment for that care.
- Confidential Information includes Your name, address, date of birth, marital status, sex, social security number, dental information, and Member information, including information about Your transactions with Us, such as Claim history and Premium payments.
- Information Disclosed:

- We may provide Confidential Information to You in order to supply You with information about Your Benefits, or if You request to inspect Your Confidential Information.
- We may provide Your Confidential Information to health care providers and to Our business associates who request Confidential Information for payment-related activities and for health care operations.
- We may provide Your Confidential Information to someone who has the legal right to act on Your behalf.
- We may provide Confidential Information to the extent necessary to comply with laws related to Workers' Compensation or similar programs.
- We may provide Confidential Information without Your written permission for matters in the public interest such as public health and safety activities or averting a serious threat to the health or safety of others.
- We may provide Confidential Information that We collect to third-parties involved in the underwriting, processing, servicing and marketing of Your Paramount Dental insurance products. We will not provide this information to any other third party for purposes other than set forth above unless We have a written agreement that requires such third party to protect the confidentiality of this information or Your written authorization.
- The law or the courts may require Us to provide Confidential Information to persons or agencies involved in regulatory, enforcement, or civil or criminal judicial activities.
- When We provide Your Confidential Information to any third party, We will provide only a limited data set, or if needed, the minimal amount of information that We deem is necessary.
- We do not disclose any Confidential Information about Our customers to anyone except as permitted or required by law.
- We must obtain Your written authorization for any disclosures of Your Confidential Information for purposes other than those listed above, including disclosures of psychotherapy notes or for marketing purposes.
- We are prohibited from using or disclosing genetic information of an individual for underwriting purposes.

Security of Your Confidential Information:

- Access of Your Confidential Information is available from Us only to persons involved in underwriting, processing information, marketing company products, or providing dental care for Your Benefit. Access must be granted to those entities to enable them to provide the excellent service You have come to expect from Paramount Dental.
- We maintain physical, electronic, and procedural safeguards that comply with state and federal standards to guard Your Confidential Information.
- If We become aware that an item of Confidential Information may be materially inaccurate, We will make a reasonable effort to confirm its accuracy and correct any error as appropriate.
- If We believe Your Confidential Information has been breached, You will receive a written notification of the suspected breach.

Individual Rights:

- You have a right to learn about the nature and substance of any Confidential Information Paramount Dental has in its files about You. We reserve the right to charge a reasonable cost-based fee for copying and postage.
- You have the right to an accounting of certain disclosures of Your Confidential Information.
- You have the right to request that We place restrictions on the way We use and disclose Your Confidential Information. We will inform You within thirty (30) days of Our decision concerning Your request. We will agree to any request to restrict the disclosure of Your Confidential Information if the disclosure is for carrying out payment or health care operations and You have paid the provider in full out of Your pocket.
- You have a right to inspect Your Confidential Information and request that We amend it in Our files.
- You have a right to obtain a copy of Your Confidential Information that We use or maintain in an electronic health record. We reserve the right to charge a reasonable cost-based fee to provide such information to You or Your specific designee.
- Individual Members who believe that the way we communicate decisions related to payment and Benefits may endanger their Confidential Information may request that We communicate with them using a reasonable alternative means or location.

Duties:

- Paramount Dental is required to abide by the terms of this Notice, and reserves the right to change the terms of this Notice at any time, provided that applicable law permits such changes. These revised practices will apply to Your Confidential Information regardless of when it was created or received. Before We

make a material change to Our privacy practices, We will provide You with a revised Notice of Privacy Practices.

- Where multiple state or federal laws protect the privacy of Your Confidential Information, We will follow the requirements that provide the greatest privacy protection.

Further information:

If You need more information about Our privacy policy, or are concerned that We may have violated Your privacy rights, please contact Paramount Dental's Privacy Officer.

You may also submit a written complaint to: Attn: Region V, Office of Civil Rights

U.S. Dept. of Health and Human Services
233 N. Michigan Ave, Ste 240
Chicago, IL 60601
Voice mail: 312.866.2359
Fax: 313.866.1807

We support Your right to protect the privacy of Your Confidential Information. We will not take action against You.

Physical Examinations and Autopsy

We reserve the right, at Our own expense, to examine a Member when and as often as may be reasonably required for the determination of a Claim. We may request an autopsy in case of death where it is not forbidden by law.

Grace Period

A grace period of thirty-one (31) days will be allowed for the payment of each Premium due after the first Premium. This coverage will remain in effect during the grace period unless You have given advance written notice of discontinuance of coverage.

If You receive advance payments of the premium tax credit and have previously paid at least one full month's premium during the benefit year, the grace period is extended to three (3) months. If all outstanding premium payment is not paid within the three (3) month grace period, Your coverage will terminate and pended claims submitted during the second and third months of the grace period will be denied and you will be responsible for payment to Your dental provider.

Notification to Insureds

Paramount Dental will notify You in writing by mail at Your last known address at least sixty (60) days prior to the Effective Date of the termination of Your insurance, a change in Your Premium, a change in Eligibility, or a change in Your Benefits.

Misstatement of Age

If the age of any individual covered under the Policy has been misstated, there will be an adjustment of Premium for the Policy so that there will be paid to Us the Premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage will not be affected.

Incontestability

Except for non-payment of Premium, the insurance provided by the Policy cannot be contested after a period of two (2) years from the date of issue of such insurance. No statement made for the purpose of effecting insurance shall void this insurance or reduce its Benefits unless contained in a written instrument signed by You, a copy of which has been furnished to You or Your beneficiary.

After the Policy has been in force for two (2) years, We will not use any statements made in Your application to void the Policy. After You have been covered under the Policy for two (2) years, We will not use any statement made in Your application to defend a Claim.

Conformity with State Statutes

If any provision of the Policy is contrary to any law to which it is subject, such provision will be amended to conform to the minimum extent necessary to satisfy legal requirements.

Coordination of this Contract's Benefits With Other Benefits

Definition:

Coordination of Benefits (COB)

A process that carriers use to determine the order of payment and amount each carrier will pay when a person receives dental services that are covered by more than one Benefit plan. COB ensures that no more than 100 percent of the lowest allowable charges for services are paid when a Member has coverage under two or more Benefits plans (dual coverage) — for example, a Child who is covered by both parents' plans.

Policy/Terms:

Coordination of Benefits

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of Benefit determination rules govern the order in which each Plan will pay a Claim for Benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay Benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the Benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Terms:

1. A Plan is any of the following that provides Benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a

group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

a. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as defined by state law; school accident type coverage; Benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under a. or b. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

2. This Plan means, in a COB provision, the part of the contract providing the health care Benefits to which the COB provision applies and which may be reduced because of the Benefits of other plans. Any other part of the contract providing health care Benefits is separate from This Plan. A contract may apply one COB provision to certain Benefits, such as dental Benefits, coordinating only with similar Benefits, and may apply another COB provision to coordinate other Benefits.

3. The order of benefit determination rules determine whether this Plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

4. Allowable Expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides Benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a Benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

a. The difference between the cost of a semiprivate hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.

b. If a person is covered by 2 or more Plans that compute their benefit payment on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

c. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

d. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and other Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary plan to determine its Benefits.

e. The amount of any benefit reduction by the Primary plan because of a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

5. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excluded coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

6. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Child resides more than one half of the plan year excluding any temporary visitation.

Order of Benefit Determination Rules:

When a person is covered by two or more Plans, the rules for determining the order of Benefit payments are as follows:

1. The Primary plan pays or provides its Benefits according to its terms of coverage and without regard to the Benefits of under any other Plan.

2. Except as provided in the following paragraph, a Plan that does not contain a Coordination of Benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

   Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holders. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide outof-network benefits.

3. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

4. Each Plan determines its order of Benefits using the first of the following rules that apply:

a. Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent, for example as an employee, Member, policyholder, Subscriber or retiree is the Primary plan and the Plan that covers the person as a Dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of Benefits between the two Plans is reversed so that the Plan covering the person as an employee, Member, policyholder, Subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

b. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one Plan the order of Benefits is determined as follows:

   i. For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:

      1. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

      2. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

      3. However, if one spouse’s plan has some other coordination rule (for example, a “gender rule” which says the father’s plan is always primary), we will follow the rules of that plan.

   ii. For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:

      1. If a court decree states that one of the parents is responsible for the Dependent Child’s health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

      2. If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage,

the provisions of Subparagraph (a) above shall determine the order of Benefits;

3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of Subparagraph (a) above shall determine the order of Benefits; or

4. If there is no court decree allocating responsibility for the Dependent Child's health care expenses or health care coverage, the order of Benefits for the Child are as follows:

a. The Plan covering the Custodial parent;

b. The Plan covering the spouse of the Custodial parent;

c. The Plan covering the non-custodial parent; and then

d. The Plan covering the spouse of the non-custodial parent.

iii. For a Dependent Child covered under more than one Plan of individuals who are not the parents of the Child, the provisions of Subparagraph (a) or (b) above shall determine the order of Benefits as if those individuals were the parents of the Child.

c. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laidoff employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of Benefits, this rule is ignored. This rule does not apply if the rule labeled 3.a. can determine the order of Benefits.

d. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, Member, Subscriber or retiree or covering the person as a Dependent of an employee, Member, Subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of Benefits, this rule is ignored. This rule does not apply if the rule labeled 3.a. can determine the order of Benefits.

e. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, Member, policyholder, Subscriber, or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

f. If the preceding rules do not determine the order of Benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of this Plan:

When This Plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any Claim, the Secondary plan will calculate the Benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total Benefits paid or provided by all Plans for the Claim do not exceed the total Allowable Expense for that Claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, Benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

Right To Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine Benefits payable under This Plan and other Plans. Paramount Dental may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining Benefits payable under This Plan and other Plans covering the person Claiming Benefits. Paramount Dental need not tell, or get the consent of, any person to do this. Each person Claiming Benefits under This Plan must give Paramount Dental any facts it needs to apply those rules and determine Benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, Paramount Dental may pay that amount to the organization that made that payment. That amount will

then be treated as though it were a benefit paid under This plan. Paramount Dental will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Paramount Dental is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that the Plan has not paid a claim properly, you should first attempt to resolve the problem by contacting Member Services at 800-727-1444. You may also contact us at www.InsuringSmiles.com. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department’s website at http://insurance.ohio.gov.