

Benefits Description	Plan Coverage
Calendar Year Maximum	\$1,000
Calendar Year Deductible	\$ 50 per person \$150 per family
Preventive Services Initial/Routine Oral Exam, Teeth Cleaning & Routine Scaling, Fluoride Treatment, Sealant (children under 17), X-rays as part of a general exam, Emergency Exam	100% no deductible
General Services Fillings, General Anesthetics, Space Maintainers	80% after deductible
Major Services Crowns, Removable & Fixed Bridges, Complete & Partial Dentures, Oral Surgery, Periodontics, Endodontics There is a 12-month waiting period for Major Services on this plan unless you were previously covered on this Employer's indemnity plan for the last continuous 12 months. If you were covered for less than 12 continuous months, your waiting period will be pro-rated.	50% after deductible 12 month wait

Your Costs: Payment from SafeGuard is based on the “usual & customary” charge that is pre-set for each procedure. This charge is determined by the complexity of the treatment and the fee most commonly charged for that procedure in a particular geographic area. This is the “maximum allowable” for any procedure and the benefit will be calculated based on the dentist’s submitted fee or the usual & customary amount - whichever is lower.

Balance Billing: If your dentist charges more than the usual & customary amount for a procedure, you are responsible for the difference between what is charged and that amount. This is called “Balance Billing”.

Limitations:

- | | |
|-----------------------------|----------------------------------------------------------------------------------|
| ⇒ Initial/Routine Oral Exam | 2 per calendar year |
| ⇒ Teeth Cleaning | 2 per calendar year |
| ⇒ Sealants | Children under 17 for permanent molars only |
| ⇒ Emergency Treatment | Services for relief of pain only |
| ⇒ X-rays | One full mouth series of periapical X-rays, including bitewings, every 36 months |

Complete Exclusions and Limitations are listed along with full Plan information in your Certificate of Insurance.

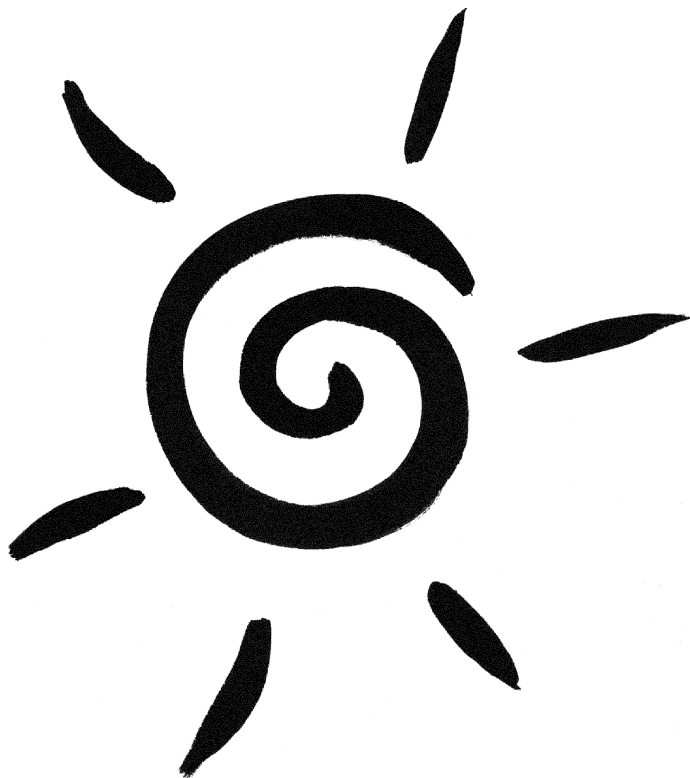
We give you more to smile about...

This brochure is your Certificate of Insurance. Inside, you will also find:

- An explanation of how to use your Indemnity Policy and a description of the many advantages.
- Your *Summary of Benefits*.

Please retain this document for reference. If you need clarification or additional information, you can contact us at **(800) 962-9633**.

Please see your Human Resources Department for a Directory of Participating Dentists.



Entire Contract - Changes and Incontestability

We typically contract with an Organization, such as your employer or association, to offer benefits to its employees or members. The Policy, the application of the Policyholder, and the individual applications, if any, of the Insured Persons make up the entire contract between the Company and the Policyholder. Any statement made by the Policyholder, or by any Covered Person shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall void the insurance or reduce the benefits under this Policy or be used in defense to a claim for loss incurred or disability commencing after the insurance coverage with respect to which claim is made has been in effect for two years from the date it became effective.

No change in the Policy will be effective until it is approved by one of the Company officers. This change and approval must be noted on or attached to the Policy. No agent may change the Policy or waive any of its provisions.

Who May Apply

The persons eligible to apply for insurance under this Policy are the employees/members of the Policyholder/Organization. You are eligible if:

- You are an employee of the company on the date it becomes a Participating Employer; or

- You become employed after the company becomes a Participating Employer and you have completed the Waiting Period specified by your employer.

The term 'employee' may include individual proprietors, partners, officers, and managers.

If a spouse or child is covered as an Eligible Employee, that spouse or child may not be covered under this Policy as a dependent. If both husband and wife are covered as Eligible Employees, an eligible child may be insured as the dependent of only one of them.

Dependent Coverage

Florida Residents: Please Also See Page 16.

Your Organization is responsible for determining dependent eligibility. In the absence of such a determination, SafeGuard defines eligible dependents to be:

- Your lawful spouse or domestic partner, if your Organization provides such coverage.
- Your unmarried children (including adopted children, stepchildren and pursuant to a court or administrative order to provide dental benefits to children) and those of the Subscriber's spouse up to the age of twenty-five (25) and depend primarily on the Enrollee for support.

- Your children who are incapable of self-sustaining employment due to developmental disability or physical handicap and who are dependent on you for their support and maintenance.
- Other dependents if your Organization provides benefits for these dependents.

Please check with your Organization if you have questions regarding your eligibility requirements.

Late Applicant Limitations

Any person who applies for coverage after his/her eligibility date is subject to a first year benefit limitation of \$100.00. This applies to all levels of coverage.

When Coverage Begins

Coverage for you and your enrolled dependents will begin on the date determined by your Organization. Newborn children or new spouses are covered the first (1st) of the month following the date you acquire the dependent (such as the day of marriage or day of birth). Your legally adopted children, foster children and stepchildren are covered from the first (1st) of the month following the date of placement. However, you must advise us of any new dependents within thirty (30) days of acquiring that dependent. Check with your Organization if you have any questions about when your coverage begins or to whom benefits under your policy may apply.

Claim Forms

We accept and encourage the use of Universal Claim Forms that are available in most dental offices. Claim Forms are also available from your benefits office. Once treatment is performed, ask your dentist to file a claim directly with us.

You and your dentist will then receive an Explanation of Benefits (EOB) from us showing your benefits payment for dental care services provided.

Making An Appointment

You may receive services from any licensed dentist. Simply call and advise them that you are covered under the indemnity policy issued by the Company.

What Are Your Costs?

Usual and Customary Charges. Payment from us is based on a "usual and customary" charge for each procedure. This amount is the maximum allowable payment. Usual and customary is determined by weighing the complexity of the treatment, and the fee most commonly charged for that service in your dentist's particular geographic area. The benefit will be calculated based on the dentist's submitted fee or the usual and customary amount - whichever is lower.

Balance Billing Charges. If your dentist charges more than the usual and customary amount for a procedure, you are responsible for the difference. For example, if your dentist charges \$120 for a procedure but the usual and customary amount is \$100, we base our payment on \$100. If you're covered at 50%, we pay \$50. You would be responsible for the remaining \$70 charged by your dentist.

Deductible. Deductible refers to the fixed dollar amount that you are responsible for each calendar year prior to any benefits being received.

Coinsurance. Benefits are based on a percentage of usual and customary charges and on the classification of the procedure; Preventive, Basic, or Major. Coinsurance refers to your share of the cost in excess of the policy benefits. For example, a policy that has 100/80/50 coverage would cover preventive services at 100% of usual and customary charges; Basic services at 80% of usual and customary charges; and Major services at 50% of usual and customary charges.

Filing a Claim

CLAIMS

If you are filing the claim, read the form carefully, answer all of the questions and attach the original, itemized bill or bills. Each bill must include;

- The Enrollee's name and Social Security number;

- Patient's name;
- A description of the procedures or services and ADA Code;
- Date services were performed;
- Amount of the charge for each service;
- Complete name, address, telephone number of the dental provider and Tax ID number if possible; and
- X-Rays may be required.

Make sure you keep a copy of all bills, documentation, and the claim form.

Your dentist may file your claim for you or you may be asked to pay the entire bill when you receive care.

PRE-TREATMENT ESTIMATE

If the cost of your services is expected to exceed \$300, the Company recommends that you ask your dentist to submit a treatment plan for a Pre-Treatment Estimate to our Claims Department. The Claims Department will process the treatment plan and send you a copy of the estimate of benefits for planned services. The estimate is based upon your benefits available at the time of processing and may change if other claims are submitted prior to completion of treatment. This gives you the opportunity to know exactly the

amount of benefits allowable before any fees are incurred.

Claims and Pre-Treatment Estimates should be submitted to:

SafeGuard
PO Box 30930
Laguna Hills, CA 92654-0930

Claims should be received by the Company within thirty (30) days after the charges are incurred or as soon as reasonably possible, but in no event later than ninety (90) days after the charge is incurred. To find out about a pending claim, you can call the Claims Department at **(800) 962-9633**.

All benefit checks must be cashed within ninety (90) days of the date on which the check was issued. If any check is not cashed during this time, it will be cancelled. You must file a new claim if the check is cancelled.

What is a Covered Benefit

What is Medically Necessary Dental Care

We cover the charges for 'medically necessary' dental care, including preventive services as well as treatment for disease, and most accidental dental injuries, as defined in this Certificate of Insurance. The amount you may receive in benefits from this policy will depend on the type of service you receive. Services fall into three categories - Preventive,

Basic and Major, and are defined in the **enclosed** *Summary of Benefits*. To be covered by this policy, a service must be medically necessary. 'Medically Necessary' means the treatment must be accepted by the dental community as safe and effective. It must also be the appropriate alternative for the situation and must be required for your condition. No benefits are paid for services, supplies or treatment not determined by this policy to be 'Medically Necessary.' Receiving a Pre-Treatment Estimate is important before you begin treatment with your dentist because it will clarify if the procedure is covered under the policy.

Please refer to the enclosed *Summary of Benefits* for a description of what type of dental care procedures are covered in your policy.

Alternative Procedures

Often, there is more than one way to treat a dental problem. For example, either a crown or a filling could be used to restore a tooth. Benefits are allowed based on the less extensive treatment. A dental consultant is asked to review each case where there is a question of alternative procedures. Receiving a Pre-Treatment Estimate is important because, when there is an alternative procedure available, we pay based on the less extensive treatment. If you and your Dentist decide you want the alternative treatment you are responsible for charges exceeding the less extensive treatment cost.

What is Not Covered

Exclusions

No benefits are payable under the Policy for any expenses incurred for:

- Dental treatment or expenses in connection with periodontal splinting;
- Internal or external bleaching procedures;
- Precision attachments on fixed or removable prosthetics;
- Treatment of congenital malformations (except in Colorado);
- Cosmetic dental care services (dental services provided solely for cosmetic purposes);
- Any dental procedure or dental care product or service or supply not listed in the Summary of Benefits in your employer's master policy;
- Periodontal maintenance, unless following active periodontal therapy;
- Prescribed drugs, medications, or training in or products used for dietary counseling, oral hygiene, or plaque control;
- Appliances or restorations whose primary purpose is to alter vertical dimension;
- Treatment by anyone other than a licensed dentist or physician, except when the services are performed by a licensed dental hygienist, in accordance with state regulations;
- Dental treatment paid under any Workers' Compensation law or act, Employers' Liability law or by any governmental program, law or agency;
- Care or treatment which is provided, or payment is made by, any governmental agency;
- Dental services which are considered experimental or investigative;
- Dental treatment or product which is not recommended by a dentist;
- Dental care treatment resulting from any intentionally self-inflicted injury or sickness;
- Dental treatment resulting from injuries sustained while committing or attempting to commit an assault or felony;
- Hospital and associated physician charges for any dental treatment which because of the Member's general health or mental, emotional or behavioral or physical limitations, cannot be performed in the dental office;

- Treatment of fractures, dislocations or sinus surgical procedures;
- Treatment by any method of any condition related to the diagnosis of temporomandibular joint disorder;
- Histopathological exams and/or the removal of tumors, cysts, neoplasm and foreign bodies;
- Dental procedures and charges incurred as part of dental implants, reimplantation and transplants;
- Orthodontic conditions unless orthodontic benefits are listed on the enclosed *Summary of Benefits*.

**What Service Are Limited
Limitations**

- Replacement of lost or stolen dentures, bridgework or other dental appliance, if replacement occurs within five (5) years of original placement date;
- Reline or rebase of denture or partials are limited to once in a twelve (12) month period;
- Any procedure started or appliance placed prior to the effective date or after the termination date of the covered person's insurance;
- Initial placement or replacement of any bridge or denture, unless such placement is necessitated by

the loss of one or more natural teeth while insured under this policy;

- Porcelain, porcelain with metal, or full gold crowns for persons under sixteen (16) years of age;
- Periodontal maintenance, unless following active periodontal therapy.

**General Provisions
Coordination of Benefits**

We coordinate our benefits with those you may be entitled to from other policies. This prevents duplication of payment if you or your dependents are covered by another group insurance plan, no fault automobile insurance or a government program, not including Medicare or Medicaid. Your combined benefits from all policies may pay up to, but no more than, the total covered expense.

The usual and customary charge will be determined. If there is a Policy primary to this one, it will pay first. Then, this Policy will pay the difference between the primary policy payment and the usual and customary fee, but no more than it would have paid if there were no other coverage.

Which Policy is Primary?

The Policy which covers a person as an employee is primary

for that person. For example, if you are covered under your spouse's Policy, that Policy is primary for your spouse and secondary for you and this policy is primary for you and secondary for your spouse.

For dependents covered by both parents' policies, the parents' birthdays will be used to determine which Policy is primary. The parent whose birthday falls first in the time of year will be primary for the children. For example, if the mother's birthday is in June and the father's in July of that same year, the mother's Policy will be primary for the children. However, if the other Policy does not use this birthday rule, the father's Policy will be primary for the children. In the case of divorced or separated parents, the Policy of the parent with custody will pay first, then the Policy of the step-parent with custody, and finally the Policy of the parent without custody.

If financial responsibility for health and dental care has been assigned to one parent by court order, the Policy of that parent will pay first.

If you are covered as an employee under two Policies and both Policies coordinate benefits, the Policy that covers you as an active employee will be primary.

If you are covered as an active employee under this Policy and as a retiree or laid off employee with the other Policy, our

Policy will pay before the other Policy for you and your eligible dependents. If the other Policy does not coordinate benefits, that Policy will be primary. If your spouse is also covered as an employee and/or retiree, those Policies will be primary for your spouse and secondary for you.

Waiting Period

Sometimes a waiting period applies before coverage can begin for major services. Any applicable waiting period is listed in the enclosed *Summary of Benefits*.

Calendar Year Maximum

This policy has a maximum benefit which details how much each insured person can receive in benefit dollars from us during a calendar year. Once this policy has paid an individual's maximum benefit, no additional expenses will be paid for that person for the remainder of the calendar year. Benefits will be available again at the beginning of the next calendar year. The Calendar Year Maximum is listed in the enclosed *Summary of Benefits*.

Calendar Year Deductible

The individual deductible is the fixed dollar amount each insured person pays for covered services each calendar year before we begin to pay benefits. If you have more than three family members enrolled, you will not be required to pay a deductible more than three times the individual deductible amount. The Calendar Year Deductible is listed in the

enclosed *Summary of Benefits*.

Once you have paid the family deductible, no other individual deductibles apply for others in your family for that calendar year.

No Loss/No Gain

If you have had continuous indemnity group dental coverage for the previous twelve (12) months with your current employer, we will apply any deductible or coinsurance payments made under the prior carrier's coverage and within the current calendar year to your new coverage. We request prior coverage information from your employer, however, we may require additional documentation from you regarding eligibility and claims information. Your latest Explanation of Benefits (EOB) from the prior carrier is usually sufficient.

Orthodontic coverage may continue if your employer's prior policy provided orthodontic coverage and the orthodontic lifetime maximum has not been met.

Arbitration

Florida Residents: Please Also See Page 16.

Claims Denials and Appeals

After receiving written proof of loss, the Company will pay all benefits then due for such covered benefits described in this policy. Benefits for any other loss covered by this policy will be paid as soon as the Company receives proper written proof. If

you feel that you did not receive benefits from this policy to which you are entitled, or if your application for benefits is denied, you may file a written appeal with the Company.

The Company will reimburse all claims or any portion of any claims from the Insured or an Insured's assignees, for payment under this Policy, within thirty (30) calendar days after receipt of such proof of loss by the Company. If the claim or portion of a claim is contested by the Company, the Insured or the Insured's assignees will be notified, in writing, that the claim is contested or denied, within thirty (30) calendar days after receipt of the claim by the Company. The notice that a claim is contested will identify the contested portion of the claim and the reasons for contesting the claim. The Company, upon receipt of the additional information requested from the Insured or the Insured's assignees will pay or deny the contested claim or portion thereof, within sixty (60) days. The Company will pay or deny any claim no later than one hundred twenty (120) days after receiving the claim. Payment will be treated as being made on the date a draft or other valid instrument which is equivalent to payment is placed in United States mail, in a properly addressed, postage paid envelope or if not so posted, on the date of delivery.

Upon written notification by the Insured, the Company will investigate any claim of improper billing by an attending dentist. The Company will determine if the Insured was

properly billed for only those procedures and services that the Insured actually received. If the Company determines that the Insured has been improperly billed, the company will notify the Insured and the dentist of its findings and will reduce the amount of payment to the dentist by the amount determined to be improperly billed.

Changes To Your Coverage

Termination of Benefits

Subject to any Continuation of Benefits Provision, such as COBRA (Consolidated Omnibus Reconciliation Act), your benefits under this Policy will terminate on the earliest of the following dates:

- The date the Policy terminates; or
- The date your Organization terminates participation; or
- If your premium is not paid before the end of the grace period, the premium due date on which that unpaid premium was due; or
- The first premium due date that follows the date your employment status changes, and either you become employed less than full time or your active work for a Participating Employer ends, except when Note A or Note B applies; or

- Policyholder has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact under the terms of this Policy; or
- Policyholder has failed to comply with a material provision of the Policy which relates to rules for employer contributions or group participation; or
- The Company is ceasing to offer coverage under this Policy.

Note A: If your active work ends because an injury or sickness disables you so that you are unable to engage in your occupation, your insurance may be continued during that disability until your premium is no longer paid. An Employer will be allowed to continue the coverage for its disabled employees only if that employer has rules regarding the length of time it will continue coverage for disabled employees.

Note B: If your active work ends because you are temporarily laid off or are on an approved leave of absence, your insurance may be continued while on layoff or an approved leave of absence, and continues until the end of the last month for which premium was paid for your insurance.

An Organization will be allowed to continue coverage for employees on layoff or leave only if that employer has rules regarding the length of time it will continue coverage for employees on layoff or leave.

Your insurance under any portion of this Policy will also end on the premium due date that falls on or that next follows the date your Organization elects to stop sponsoring the Policy. Except for non-payment of premium, we will provide **your organization** at least **forty-five (45)** days prior written notice of cancellation, expiration, nonrenewal, or of a change in rates.

Termination of Your Dependent's Benefits

Subject to any Continuation of Benefits Provision, such as COBRA, your dependent's benefits under the Policy will terminate on the earliest of the following dates:

- The premium due date on which an unpaid premium was due, if your dependent's premium is not paid before the end of the grace period; **or**
- The date your insurance terminates for any reason other than death; **or**
- With respect to your spouse only, the date you and your spouse's divorce becomes final; or

- In the event of your death, dependent Dental Expense Benefits may be continued for a period of ninety (90) days from the date the insured dies but only if the Employer continues to remit the necessary premium and does not otherwise cancel the insurance.

Continuation of Coverage

You and your eligible dependents may be eligible to retain coverage in accordance with federal COBRA requirements. You and your dependents may be eligible for Medicare benefits. Please contact your Organization for further information and details.

COBRA

An employee or any other qualified beneficiary who is disabled within sixty (60) days of termination or reduction in hours, and who elects COBRA, can elect continuing coverage for a period of twenty-nine (29) months from the date coverage was lost or the date of the qualifying event (as elected by the employer), instead of the usual eighteen (18) months. The intent of this change is to permit the employee and employee's non-disabled dependents to continue coverage until such time as this benefit can be replaced with Social Security disability benefits.

Extension of Benefits

This policy provides for an extension of benefits in the event of the total disability of an Insured at the date of discontinuance of this policy. The extension will be granted regardless of whether the Policyholder or other entity secures replacement coverage from a new insurer or foregoes the provision of coverage. Please see your Policy for further details.

Conformity with State Statutes

Any provision of the Policy which, on its effective date, is in conflict with the laws of the state in which the Policy was delivered or issued for delivery, is amended to conform to the minimum requirements of such laws.

Definitions

Benefit Year. The consecutive twelve month period of coverage, as defined by the Policyholder.

Calendar Year. The 12 month period commencing at 12:01 A.M. on January 1st and ending at 12:00 A.M. on the following December 31 and each subsequent 12 month period thereafter.

Covered Person or Individual. An Eligible Member or Eligible Dependent whose coverage under this Policy is in force with respect to any covered benefits.

Dentist. A person licensed as a dentist by the state in which he or she is practicing that entitles the dentist to provide

dental care services in accordance with state statutes and regulations.

Dental Hygienist. A person licensed by the state in which he or she is practicing that entitles the dental hygienist to provide dental care services in accordance with state statutes and regulations.

Eligibility. Any person upon becoming a member of the Policyholder Insurance Trust, or any person becoming employed by a covered employer is eligible to apply for insurance under this Policy, subject to underwriting rules and requirements of the Insurance Company.

Emergency Dental Care Services. Dental services rendered for the relief of acute pain, bleeding, infection, fever, or for conditions that may result in disability or death, and where delay of treatment would be medically inadvisable.

Injury. Bodily injury of a Covered Person caused by an accident occurring while this Policy is in force and resulting directly and independently of all other causes in expenses covered by this Policy when said expenses are incurred while this Policy is in force as to the Covered Person.

Insured. The Covered Person eligible to subscribe to the benefits provided under this Policy. Eligibility will be determined by the employer or Organization. Insured is sometimes referred to as Employee, Enrollee or Covered Person, Individual or You.

Medically Necessary. Those services or supplies which meet all the criteria listed herein:

1. It is provided for the treatment or diagnosis of a covered injury or illness; and
2. It is appropriate for the symptoms, consistent with the diagnosis, and is otherwise in accordance with generally accepted medical/dental practice and professionally recognized standards; and
3. It is the most appropriate supply or level of service needed to provide safe and adequate care.

Organization. The employer or other entity which has contracted with the Company to insure benefits under this Policy.

Policy. Shall mean the insurance coverage provided by this Policy to a Covered Person.

Usual and Customary Charges. The usual charge which takes into account the complexity of the treatment, and the fee most commonly charged for a particular service in a particular geographic area.

We, Us, Company, Insurance Company, SafeHealth, SafeGuard. SafeHealth Life Insurance Company.



FOR CALIFORNIA RESIDENTS ONLY

Cal-COBRA

You may be eligible to continue coverage under the current policy upon a qualifying event as defined under the California Continuation of Benefits Replacement Act ("Cal-COBRA"). A qualifying event is defined as any of the following events that, but for the election of continuation coverage, would result in a loss of coverage under your policy:

- the death of the covered employee or Subscriber;
- the termination or reduction of hours of the covered employee's or subscriber's employment, except that termination for gross misconduct does not constitute a qualifying event;
- the divorce or legal separation of the covered employee from the covered employee's spouse; or
- the loss of dependant status by dependant enrolled in the Organization benefit policy.

Upon election, you will be able to continue your policy, subject to the terms and conditions of the Organization contract and the requirements of Cal-COBRA.

The continuation of your coverage will only be provided for the balance of the period that you would have remained covered under your prior policy and Organization contract, had your employer not terminated the Organization contract or the contract with your previous Organization benefit policy. To be eligible for such continuation of benefits, you must notify us

(or your employer if the employer has contracted to perform the administrative services), within sixty (60) days of the date of your qualifying event. Failure to make such notification within your required sixty (60) days, will disqualify you from receiving continuation coverage.

If you wish to continue coverage, you must request such continuation of coverage in writing and deliver it via first class mail, or other reliable means of delivery, to us or to your employer, within the sixty (60) day period following the latter of:

- (1) the date of the qualifying event;
- (2) the date you are given notice of the ability to continue coverage by us or your employer;
- (3) the date coverage under your employer's policy terminates.

Within fourteen (14) days of receiving your notice of a qualifying event, we or your employer (whomever contracts to perform the notice and administrative services) will provide you with the necessary benefits information, premium information, enrollment forms, and instructions. At such time, you will be required to pay the amount of premium that is set forth in your notice. Your first premium payment for the initial three (3) months of coverage must be delivered by certified mail or other reliable means of delivery to us or your employer within forty-five (45) days of the date you provided written notice to us or your employer, of your election to continue coverage. Failure to submit the correct premium amount within such forty-five (45) day period, will disqualify you from receiving continuation coverage. Quarterly payments will be due thereafter in accordance with a billing from us.

If you had continuation coverage that has been terminated under a prior Organization benefit policy, you may continue such coverage for the balance of the period if you would have remained covered under the prior Organization benefit policy. The requirements for your election to continue coverage and payment of the required premiums are the same as described above. However, your continuation coverage shall terminate if you fail to comply with the requirements pertaining to enrollment in, and payment of, premiums to your new policy within thirty (30) days of receiving notice of the termination of your prior Organization benefit policy.



FOR FLORIDA RESIDENTS ONLY

Dependent Coverage

Dependents eligible under this Policy are your lawful spouse and any children until the end of the calendar year in which the child reaches age 25 if they are full-time or part-time students or the child is living in your household and is dependent upon you for support.

Arbitration

Claims Denials and Appeals

After receiving written proof of loss, the Company will pay all benefits then due for such covered benefits described in this Certificate of Insurance. Benefits for any other loss covered by this Policy will be paid as soon as the company receives proper written proof. If you feel that you did not receive benefits from this Policy to which you are entitled, or if your application for benefits is denied, you may file a written appeal with the company.

The Company will reimburse all claims or any portion of any claims from the Insured or an Insured's assignees, for payment under this Policy, within forty-five (45) days after receipt of such proof of loss by the Company. If the claim or portion of a claim is contested by the Company, the Insured or the Insured's assignees will be notified, in writing, that the claim is contested or denied, within forty-five (45) days after receipt of the claim by the Company. The notice that a claim is contested will identify the contested portion of the claim and the reasons for contesting the claim. The Company, upon receipt of the additional information requested from the Insured or the Insured's assignees; will pay or deny the contested claim or portion thereof, within sixty (60) days. The Company will pay or deny any legitimate claim no later than one hundred twenty (120) days after receiving the claim. Payment will be treated as being made on the date a draft or other valid instrument which is equivalent to

payment is placed in United States mail, in a properly addressed, postage paid envelope or if not so posted, on the date of delivery.

Upon written notification by the Insured, the Company will investigate any claim of improper billing by an attending dentist. The Company will determine if the Insured was properly billed for only those procedures and services that the Insured actually received. If the Company determines that the Insured has been improperly billed, the Company will notify the Insured and the dentist of its findings and will reduce the amount of payment to the dentist by the amount determined to be improperly billed.

If reduction is made due to such notification by the Insured, the Company will pay to the Insured, twenty percent (20%) of the amount of the reduction up to \$500.00.

Any dispute between you and the Company regarding its decision must be submitted to binding arbitration. This arbitration will be held before a designated neutral arbitrator appointed by the American Arbitration Association and conducted according to the rules of that association. The arbitration will take place in Ft. Lauderdale, Florida, and the findings of the arbitrator will be final and binding.

In Florida, all overdue payments shall bear simple interest at the rate of ten percent (10%) per year.

Note: In the absence of fraud, all statements made by applicants or the policyholder, or by the Insured, shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the Insured, a copy of which has been furnished to such policyholder or to such person or his or her beneficiary.

Summary of Benefits

The information below provides descriptions of the most common procedures from each treatment category along with any usage restrictions.

<u>Type of Service</u>	<u>Description</u>	<u>Coverage</u>
PREVENTIVE		
• Clinical Oral Evaluation	Initial/routine exams	Limit 2 per calendar year
• Prophylaxis	Teeth cleaning	Limit 2 per calendar year
• Sealants	Application of dental material to prevent decay	Limited to children under the age of 17 for permanent molars only
• Palliative treatment	Emergency treatment of dental pain	Limited to services for relief of pain only
• Radiographs	X-rays	Limited to one full mouth series of periapical X-rays, including bitewings, every 36 months
BASIC/GENERAL		
• Restorative	Fillings	Amalgam (silver) fillings on posterior teeth and composite (white) fillings for anterior teeth to restore injured or decayed teeth
• General Anesthetics	IV sedation or general anesthesia	Only for oral surgery or periodontal surgery
• Space Maintenance	Space maintainers	Fixed or removable, acrylic or stainless steel appliances to maintain space for primary teeth prematurely lost or extracted under this coverage

<u>Type of Service</u>	<u>Description</u>	<u>Coverage</u>
MAJOR		
• Crowns - single restoration only	Caps	Limited to once every five years. Porcelain on molar teeth is considered cosmetic and benefits will be paid based on full cast base metal crown.
• Inlay/onlay	Metal and porcelain cast inlays/onlays	Limited to once every five years. Porcelain on molar teeth is considered cosmetic and benefits will be paid based on full cast base metal inlay/onlay. Not covered when used as a retainer in a bridge.
• Fixed Prosthodontics	Bridges	Limited to once every five years. Initial placement is covered only if a tooth is lost or extracted while covered under this plan.
• Removable Prosthodontics	Dentures and partials	Limited to once every five years.
• Oral Surgery	Extractions and some surgical procedures	
• Periodontics	Treatment of diseases of the gum and supporting structures of the teeth	Periodontal scaling and root planing limited to once per 12 month period in each quadrant. Periodontal maintenance covered only following active periodontal therapy.
• Endodontics	Root canal therapy	Pulp caps are not covered.

This policy is underwritten by:

SafeHealth Life Insurance Company
 PO Box 30930
 Laguna Hills, CA 92654-0930
 Phone: (800) 962-9633