STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

CERTIFICATE AND SUMMARY PLAN DESCRIPTION:

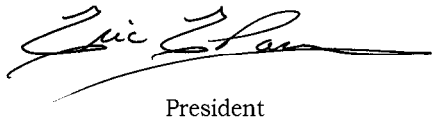
GROUP DENTAL INSURANCE

Policyholder:	Pacific Coast Shipyards Metal Trades Trust Fund
Policy Number:	516739-A
Effective Date:	January 1, 1994

A Group Policy has been issued to the Policyholder. We certify that you will be insured as provided by the terms of the Group Policy. If your coverage is changed by an amendment to the Group Policy, we will provide the Policyholder with a revised Certificate or other notice to be given to you.

Possession of this Certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate.

"We", "us" and "our" mean Standard Insurance Company. "You" and "your", as indicated by their usage, mean the Member, the Dependents, or both. All other defined terms appear with the initial letter capitalized. Section headings, and references to them, appear in bold face type.



President

GC190-DENT

CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION ACT

SUMMARY DOCUMENT AND DISCLAIMER

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the California Life and Health Insurance Guarantee Association ("CLHIGA"). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guarantee Association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guarantee Association is not unlimited, however, as noted below, and is not a substitute for consumers' care in selecting insurers.

The California Life and Health Insurance Guarantee Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the guarantee association to induce you to purchase any kind of insurance policy.**

Policyholders with additional questions should first contact their insurer or agent or may then contact:

The California Life and Health Insurance Guarantee Association

PO Box 17319

Beverly Hills CA 90209-3319

OR

Consumer Services Division

California Department of Insurance

300 S Spring St, 14th Fl

Los Angeles CA 90013

The state law that provides for this safety-net coverage is called the California Life and Health Guarantee Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

COVERAGE

Generally, individuals will be protected by the California Life and Health Insurance Guarantee Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guarantee Association if:

Their insurer was not authorized to do business in this state when it issued the policy or contract;

Their policy was issued by a health care service plan (HMO, Blue Cross, Blue Shield), a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;

They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.

The Guarantee Association also does not provide coverage for:

Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contract holders, not individuals;

Employer or association plans, to the extent they are self-funded or uninsured;

Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

Any policy of reinsurance unless an assumption certificate was issued;

Interest rate yields that exceed an average rate;

Any portion of a contract that provides dividends or experience rating credits.

LIMITS ON AMOUNT OF COVERAGE

The Act limits the Association to pay benefits as follows:

LIFE AND ANNUITY BENEFITS

80% of what the insurance company would owe under a policy or contract up to $100,000 in cash surrender values,

$100,000 in present value of annuities, or

$250,000 in life insurance death benefits.

A maximum of $250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.

HEALTH BENEFITS

A maximum of $200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

PREMIUM SURCHARGE

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for health insurance policies to which the Act applies.

CALIFORNIA NOTICE OF COMPLAINT PROCEDURE

Should any dispute arise about your premium or about a claim that you have filed, write to the company that issued the group policy. If the problem is not resolved, you may also write to the State of California, Department of Insurance, Consumer Services Division, 300 S. Spring Street, 14th FL, Los Angeles, CA 90013, or call toll-free 1-800-927-HELP (4357). This notice of complaint procedure is for information only and does not become a part or condition of this group policy/certificate.

Table of Contents

Index of Defined Terms

The page number shown below is where the term is defined. For terms defined by an entire section, the page number below is the page on which that section begins.

COVERAGE FEATURES

This section contains many of the features of your dental insurance. Other provisions, including exclusions and limitations, appear in other sections. Please refer to the text of each section for full details. The Table of Contents and the Index of Defined Terms help locate sections and definitions.

GENERAL POLICY INFORMATION

Group Policy Number:	516739-A
Policyholder:	Pacific Coast Shipyards Metal Trades Trust Fund
Employer(s):	Any employer which participates in the Pacific Coast Shipyards Metal Trades Trust and makes contributions pursuant to the trust agreement.
Group Policy Effective Date:	January 1, 1994
State of Issue:	California

BECOMING INSURED AS A MEMBER

To become insured you must: (a) Be a Member; (b) Complete your Eligibility Waiting Period; and (c) Meet the requirements in **When Insurance Becomes Effective**. Other information is found in **Late Enrollment Penalty** and **Reinstatement**.

Definition of Member:

You are a Member if contributions on your behalf are made by the Employer to the trust fund for the maintenance of the health and welfare plan, and you are:

1. An active employee who meets the eligibility rules established by the Pacific Coast Shipyards Metal Trades Trust Fund;
2. Employed in California, Washington or Oregon; and
3. A citizen or resident of the United States or Canada.

You are not a Member if you are:

1. Covered under the Policyholder sponsored prepaid dental coverage plan*; or
2. A full-time member of the armed forces of any country.

*During an Annual Enrollment Period you may elect to terminate coverage under the Policyholder-sponsored prepaid dental coverage plan. Annual Enrollment Periods occur each year during the period from February 15 to March 15. Coverage under the Group Policy ill not be effective prior to the following April 1.

Class Definition: None

Eligibility Waiting Period: You are eligible on the first day of the Eligibility Period following a Qualifying Period in which you are credited with at least 400 hours, determined by the minimum hourly contribution required by the Policyholder and the rate at which your Employer contributes.

However, if you have not been insured under the Group Policy during the preceding 12 months, you may become eligible on the first day of the Eligibility Period following two Qualifying Periods for which you are credited with at least 400 hours, determined by the minimum hourly contribution required by the Policyholder and the rate at which your Employer contributes.

Eligibility Period means the period from January 1 through March 31 and each successive three calendar month period thereafter.

Qualifying Period means the period from December 1 through the last day of February and each successive three calendar month period thereafter.

OTHER PROVISIONS

Preferred Provider Organizations:	Ameritas PPO
Dependents Coverage:	Yes
Coverage for Dependents covered under another group dental plan:	Yes
FEDERAL COBRA Continuation:	Yes. The FEDERAL COBRA continuation rate is a percentage of the contribution rate currently in effect on each due date. The contribution rate may change after you cease to be Actively At Work. The percentage is as follows: 18 Month Continuation - 102% 29 Month Continuation - 102% during the first 18 months, 150% during the next 11 months 36 month Continuation - 102%
CAL-COBRA Continuation:	Yes. The CAL-COBRA continuation rate is a percentage of the contribution rate currently in effect on each due date. The contribution rate may change after you cease to be Actively At Work. The percentage rate is 102%.
Orthodontic Dental Benefits:	Yes
Extension of Benefits under Prior Plan:	The first 30 days following the effective date of your Insurance.
Prosthetics Limitation:	None, if your Insurance becomes effective on the Group Policy Effective Date. 36 months, if your Insurance becomes effective after the Group Policy Effective Date.
Strike Continuation:	Yes. The Strike Continuation premium percentage is 120% of the Premium Rate.

BENEFIT WAITING PERIOD

Major Dental Expenses:	None
Orthodontic Dental Expenses:	None

See **Dental Benefit**, D. Benefit Waiting Period for more information.

SCHEDULE OF DENTAL BENEFITS

Dental Expenses	Dental Benefit Percentage
Preventive Dental Expenses:	100%
Basic Dental Expenses:	90%
Major Dental Expenses:	70%
Orthodontic Dental Expenses:	50%

Deductible Amount

The Deductible Amount is satisfied for each Insured Person who incurs Basic and Major Dental Expenses equal to: $50.

The Deductible Amount is satisfied for a family of three or more Insured Persons when incurred Basic and Major Dental Expenses equal three times the Deductible Amount. Only the Deductible Amount of each Insured Person's Basic and Major Dental Expenses is applied to satisfy the family Deductible Amount. Any Basic and Major Dental Expenses applied toward a Insured Person's Deductible Amount during the last three months of a Policy Year will be applied to the Insured Person's Deductible Amount for the following Policy Year.

There is no Deductible Amount for: Preventive or Orthodontic Dental Expenses.

Maximum Amounts

All Dental Benefits other than Orthodontic Dental Benefits:	$2,000 per Policy Year for each Insured Person
Orthodontic Dental Benefits:	$1,000 lifetime maximum for each Insured Person

The **Coordination Of Benefits** section applies if an Insured Person has dental coverage under more than one Plan.

Policy Year:	The period from January 1, 1994 through December 31, 1994 and each successive 12 month period while the Group Policy remains in effect.

PREMIUM CONTRIBUTIONS BY MEMBERS

Members:	Noncontributory
Dependents:	Noncontributory

ERISA SUMMARY PLAN DESCRIPTION INFORMATION

Name of Plan:	Dental Insurance
Name, Address of Plan Sponsor:	Pacific Coast Shipyards Metal Trades Trust Fund 5 Third St Ste 525 San Francisco CA 94103-3206
Plan Sponsor Tax ID Number:	94-1248513
Plan Number:	501
Type of Plan:	Group Insurance Plan
Type of Administration:	Contract Administration
Name, Address, Phone Number of Plan Administrator:	Plan Sponsor (415) 982-3123
Name, Address of Registered Agent for Service of Legal Process:	Plan Administrator
If Legal Process involves Claims For Benefits Under The Group Policy, Additional Notification of Legal Process Must Be Sent To:	Standard Insurance Company 1100 SW 6th Ave Portland OR 97204-1093
Sources of Contributions:	Employer/Member
Funding Medium:	Standard Insurance Company - Fully Insured
Plan Fiscal Year End:	June 30

INTRODUCTION

A. Insuring Clause

We will pay Dental Benefits according to the terms of the Group Policy for Dental Expenses Incurred by you while you are insured under the Group Policy, after we receive satisfactory Proof Of Loss satisfactory to us.

Takeover Provision: A Dental Benefit will be paid for the following Dental Expenses Incurred before the Effective Date of your Insurance if: (a) you were insured under the Prior Plan on the day before the Effective Date of your Insurance; (b) dental benefits would have been paid under the Prior Plan if it had remained in force; and (c) the dental service or supply is provided after the end of the Benefit Extension Period under the Prior Plan as shown in the **Coverage Features**:

1. Bridgework, crown or onlay.
2. Placement or modification of a full or partial denture.
3. Root canal therapy.

B. Free Choice Of Dental Professional

You may select a Dental Professional of your choice. You may choose either a PPO Dental Professional or a Non-PPO Dental Professional. However, the benefit and terms of your coverage may differ according to your choice.

The Dental Professional you select is responsible for the quality of dental care you receive. We are not responsible for any injuries you may suffer while receiving dental care.

C. Predetermination Of Dental Benefit

If your Dental Professional gives us a Treatment Plan, we will tell you and your Dental Professional the amount of Dental Benefit we will pay. We recommend your Dental Professional give us a Treatment Plan when dental services and supplies may result in Dental Expenses of $250 or more.

Treatment Plan means the Dental Professional's report which lists the dental services and supplies recommended and the charge for each item. We may request additional information.

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DENTAL BENEFIT

A. Dental Benefit

The Dental Benefit is a percentage of the Reasonable and Customary Charge for those dental services and supplies which are listed in **Dental Expenses**. The percentage that applies is stated in the **Coverage Features**.

B. Deductible Amount

Deductible Amount means the amount of (a) the Reasonable and Customary Charge with respect to a Non-PPO Dental Professional, or (b) the Negotiated Fee Schedule with respect to a PPO Dental Professional, for Dental Expenses you must incur during the Policy Year before we will pay a Dental Benefit.

The Deductible Amount is stated in the **Coverage Features**.

C. Maximum Amount of Dental Benefit

The Maximum Amounts of Dental Benefits are stated in the **Coverage Features**.

D. Benefit Waiting Period

The **Coverage Features** states the length of the Benefit Waiting Period and which Dental Expenses are subject to a Benefit Waiting Period.

Your Insurance must be in effect continuously for the length of the Benefit Waiting Period stated in the **Coverage Features** before Dental Expenses subject to the Benefit Waiting Period will be covered. Charges incurred for Dental Expenses which are not covered during the Benefit Waiting Period will not be applied toward the Deductible Amount.

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DENTAL EXPENSES

Dental Expenses means the charges for the dental services and supplies provided by your Dental Professional and listed below.

A. Preventive Dental Expenses

Preventive Dental Expenses means charges for the following services and supplies:

1. Prophylaxis, but only once in any 5-month period.
2. Oral Examinations of the mouth and teeth, but only once in any 5-month period.
3. Fluoride treatments for a Child under age 16, but only once in any 5-month period.
4. The Dental X-rays in a through d below.
    a. One set of full mouth or panoramic X-rays in any 3-year period.
    b. One set of bitewing X-rays in any 5-month period.
    c. Periapical X-rays.
    d. One set of occlusal X-rays in any 2-year period.
5. Bacteriologic cultures and examination of oral tissue excised for biopsy.
6. Emergency palliative treatment.
7. Space maintainers designed to preserve the space between teeth caused by the premature loss of a primary tooth. Orthodontic space maintainers are not included.
8. Application of sealants for a Child under age 17, but only once in any 3-year period and for posterior teeth only.

B. Basic Dental Expenses

Basic Dental Expenses means charges for the following services and supplies:

1. Endodontic treatment, including pulpotomy, apicoectomy, retrograde filling, root canal therapy and pulp capping.

    Charges for root canal therapy for which the pulp chamber was opened before the effective date of your Insurance will not be covered during the Extension of Benefits period shown in the **Coverage Features**, if you were insured under the Prior Plan.
2. Simple extraction of one or more teeth.
3. Oral surgery and postoperative treatment in a through f below.
    a. Surgical extraction of one or more teeth.
    b. Extraction of the tooth root.

c. Alveolectomy, alveoplasty and frenectomy.

d. Excision of pericoronal gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy.

e. Reimplantation or transplant of a natural tooth.

f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst.

4. Periodontal services and treatments in a through i below.

a. Periodontal prophylaxis, but only once in any 2 1/2-month period.

b. Root scaling and root planing, but only once per quadrant of the mouth in any 5-month period.

c. Occlusal adjustment if performed in conjunction with covered periodontal surgery.

d. Gingivectomy, gingival curettage, and mucogingival surgery.

e. Osseous surgery including flap entry and closure.

f. Pedical or free soft tissue grafts.

g. Periodontal appliances, but only once in any 5- year period.

h. Bone grafts, either single or multiple.

i. Provisional splinting, either intracoronal or extracoronal.

5. Study models, but only once in any 3-year period.

6. Crown buildups.

7. Pin retention of fillings.

8. Fillings using amalgam, silicate, acrylic, synthetic porcelain, and composite filling material to restore teeth broken down by decay or injury.

Fillings performed on the following surfaces of anterior teeth will be paid as single-surface fillings: Mesiolingual; distolingual; mesiobuccal; and distobuccal.

9. Recementing inlays, onlays and crowns.

10. Recementing bridges.

11. Repairs to full and partial dentures and bridges, but only once in any 2-year period. No Dental Benefit will be paid for repair costs that exceed 20% of the replacement cost.

12. General anesthetics, analgesics, and intravenous sedation when given as part of covered oral surgery.

13. Antibiotic injections given by the treating Dental Professional.

C. Major Dental Expenses

Major Dental Expenses means charges for the following services and supplies:

1. Restorative services and supplies in a through c below.

a. Gold or porcelain inlays, onlays, and crowns but only when the tooth, because of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling material.

Charges for the above restorative services, for a tooth which was prepared before the effective date of your Insurance will not be covered during the Extension of Benefits period shown in the **Coverage Features**, if you were insured under the Prior Plan.

b. Stainless steel crowns.

c. Post and core.

2. Prosthetic services and supplies in a through c below.

   a. Initial placement of full or partial dentures or fixed bridgework (including acid-etch metal bridges) but only if the denture or bridgework includes replacement of a natural tooth which is extracted or lost while your dental insurance under your Employer's group dental plan is in effect. This limitation will not apply after your Insurance has been in effect for the length of the Prosthetics Limitation shown in the **Coverage Features**.

   b. Addition of one or more teeth to an existing partial denture, but only if required to replace one or more natural teeth extracted or lost while your dental insurance under your Employer's group dental plan is in effect. This limitation will not apply after your Insurance has been in effect for the length of the Prosthetics Limitation shown in the **Coverage Features**.

      Charges for the above restorative services, for a tooth which was prepared before the effective date of your Insurance will not be covered during the Extension of Benefits period shown in the **Coverage Features**, if you were insured under the Prior Plan.

   c. Relining or rebasing of existing removable full or partial dentures, but only if it has been at least one year since the denture was placed. Charges for these services are covered only once in any 2-year period.

3. Replacement of permanent devices in a and b below.

   a. Replacement of an existing inlay, onlay, or permanent crown but only if it has been at least 5 years since the restoration was initially placed or last replaced. However, this 5-year limitation will not apply if replacement is made necessary by the extraction of one or more natural teeth while your Insurance is in effect.

   b. Replacement of permanent full or partial dentures or permanent fixed bridgework which cannot be made serviceable, but only if it has been at least 5 years since the permanent denture or bridgework was initially placed or last replaced.

      No Dental Benefit will be paid for any duplicate prosthetic appliance or the replacement of any lost, missing, or stolen prosthetic appliance.

4. Replacement of Temporary Devices, as follows:

   Replacement of a Temporary Device with a permanent device is covered. However, the Dental Benefit payable for the permanent device is reduced by any amount we paid for placement of the Temporary Device.

   Temporary Device means a crown, a full or partial denture, or fixed bridgework, that has been in place for less than 12 months.

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D. Orthodontic Dental Expenses

The **Coverage Features** states who is covered for Orthodontic Dental Expenses and whether a Benefit Waiting Period applies.

Orthodontic Dental Expenses means charges for the following services and supplies:

1. Cephalometric film.

2. Removable, fixed or cemented appliance for tooth guidance or for interceptive orthodontic treatment, including impressions, installation and all adjustments within 6 months of installation.

3. Comprehensive (full-banded) orthodontic treatment of transitional or permanent teeth.

No Dental Benefit will be paid for Orthodontic Dental Expenses incurred after the date Insurance ends.

EXCLUSIONS

The charges in 1 through 18 below are not covered.

1. Charges for services or supplies other than the Dental Expenses listed in the Group Policy.
2. Charges for office visits or consultations.
3. Charges which exceed the Reasonable and Customary Charge for the services or supplies provided.
4. Charges which exceed the Reasonable and Customary Charge for the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.
5. Charges for services or supplies for which no charge would be made in the absence of insurance or for which you are not obligated to pay.
6. Charges for services or supplies which do not have a reasonably favorable prognosis or which are not necessary according to accepted standards of dental practice.
7. Charges for services or supplies which are not generally accepted by the dental profession or are experimental or investigational.
8. Charges for services or supplies that are primarily for cosmetic purposes.
9. Charges for Periodontal Splints, except as provided in item 4.i. of Basic Dental Expenses.
10. Charges for appliances or restorations to increase vertical dimension, to restore an occlusion, or for gnathologic recordings.
11. Charges for services or supplies related to diagnosis or treatment of temporomandibular joint disorder or craniomandibular disorder.
12. Charges for: implants; precision attachments or semi- precision attachments; acid etch (other than acid etch metal bridge retainers); bite regulation; bite analysis; treatment of fractures; orthognathic surgery; instruction in dental plaque control or dental hygienics; or nutritional counseling.
13. Charges for services or supplies for which you are entitled to benefits under any workers' compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an Injury or Sickness arising out of or in the course of any employment for wage or profit.
14. Charges for Dental Expenses for which benefits are payable under any medical expense plan or under any liability policy including, but not limited to, an automobile policy or a homeowner's policy.
15. Charges for services or supplies received as a result of any dental condition caused or contributed to by War or any act of War. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.
16. Charges that result from: (a) a change of Dental Professionals while receiving treatment; or (b) receiving care from more than one Dental Professional for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one Dental Professional had performed all the required dental service.
17. Charges for maxillo-facial surgery, myofunctional therapy, cleft palate treatment, or treatment of micrognathia or macrognathia.
18. Charges for lingually placed direct bonded appliances and arch wires.

COORDINATION OF BENEFITS

This section applies if an Insured Person has dental coverage under more than one Plan. All Dental Benefits are subject to this section.

A. Definitions For This Section

1. Plan means the Group Policy and any of the following dental plans providing benefits for dental services or supplies:

   a. Any group or blanket insurance policy.

   b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.

   c. Any labor/management trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

   d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does not include a state plan under Medicaid (Title XVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non- governmental program.

   e. Any other group-type coverage which is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.

   Each contract or other arrangement for coverage under a through e above is a separate Plan. Also, if an arrangement has two parts and the coordination of benefits rules apply only to one of the two, each of the parts is a separate Plan.

2. Plan does not include the following:

   a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual Health Maintenance Organizations or other prepayment service, group practice plans.

   b. Coverages covering grammar school, high school and college students for accidents only, including athletic injuries.

3. Allowable Expense means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering you. When a Plan provides services rather than cash benefits, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had claim been made for them.

4. Claim Determination Period means a Policy Year, but does not include any time when you were not insured under the Group Policy.

B. Order Of Benefits: Which Plan Pays First

If payment under the Group Policy must be made first, that payment will not be reduced because of this section.

If a Plan does not have a coordination of benefits provision, that Plan must provide benefits first.

If a Plan also has a coordination of benefits provision, 1 through 5 below will apply.

1. The benefits of a Plan which covers a person as an employee, member or subscriber are determined before those of a Plan which covers the person as a dependent.

2. If a Dependent Child is covered by different parents under separate Plans, the benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined first. If both parents have the same birthday, the benefits of the Plan which covered a parent longer are determined first.

   If the other Plan has the gender rule, the other Plan will determine the order of benefits.

3. If a Dependent Child is covered by divorced or separated parents under two or more Plans, benefits for that Child will be determined in the following order:

   a. The Plan of the parent with custody.

   b. The Plan of the spouse of the parent with custody.

   c. The Plan of the parent not having custody.

   However, if the specific terms of a court decree establish a parent's responsibility to provide coverage, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period during which benefits are paid or provided before the entity has that actual knowledge.

4. The benefits of a Plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, this rule will be ignored.

5. If the rules above do not establish the order of benefits, the benefits of a Plan that has covered a person for a longer period will be determined first.

C. Effect On Benefits When Other Plan Pays First

   If all or any part of a Dental Expense for which you claim Dental Benefits is an Allowable Expense under any other Plan, then Dental Benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the Allowable Expense.

   However, the amount by which Dental Benefits have been reduced during the Claim Determination Period will be used by us to pay Allowable Expenses not otherwise paid, which were incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims that have been submitted in the current Claim Determination Period.

   If Dental Benefits are reduced as described above, each benefit will be reduced proportionately. The total amount paid will be charged toward the Maximum Amounts.

D. Right To Receive And Release Information

   We may without your consent and notice to you:

   1. Release any information with respect to your coverage and benefits under the Group Policy; and

   2. Obtain from any other insurance company, organization, or person any information with respect to your coverage and benefits under another Plan.

   You must provide us with any information necessary to coordinate benefits.

E. Facility Of Payment

   Whenever payments which should have been made by us according to this section have been made under another Plan, we may pay the other Plan the amount we should have paid you. Any such payment will be a Dental Benefit and we will be fully discharged from liability to the extent of that payment.

WHEN A MEMBER'S INSURANCE BECOMES EFFECTIVE

Your insurance becomes effective on the date you become eligible.

BECOMING INSURED AS A DEPENDENT

A. Definition Of Dependent

Dependent means the Member's Spouse or Child. Dependent does not include a full-time member of the armed forces of any country.

Spouse means:

1. A person to whom you are legally married; or
2. Your Domestic Partner. Your Domestic Partner means an individual recognized as such under California state law.

For purposes of insurance under the Group Policy, Spouse does not include a person who is a full-time member of the armed forces of any country or a person from whom you are divorced or legally separated or from whom you have terminated a Domestic Partner relationship.

Child means the Member's unmarried child, from live birth to age 26. Child includes a stepchild and the child of your Spouse living in the Member's home, an adopted child, and a foster child.

Disabled Child means a Child who, on and after the date on which Insurance would end because of the Child's age, is continuously:

1. Incapable of self-sustaining employment because of mental retardation or physical handicap; and
2. Chiefly dependent upon the Member for support and maintenance, or institutionalized because of mental retardation or physical handicap.

   The Member must give us proof of Disabled Child status on our forms and within 31 days after the date on which Insurance would otherwise end because of the Child's age. At reasonable intervals thereafter, we may require further proof, but not more often than once a year. We may have your Child examined at our expense.

   A Disabled Child's Insurance may continue unless otherwise terminated under **When Insurance Ends.**

B. Eligibility For Insurance

You are eligible for Insurance if you are a Dependent of an insured Member, unless:

1. You are eligible for Insurance as a Member.
2. You are covered under another group dental plan, and the **Coverage Features** states that such Dependents are not covered.

C. When Insurance for Dependents Becomes Effective

Dependents Insurance becomes effective on the date you become eligible.

DE.EF.35X

WHEN INSURANCE ENDS

Insurance ends automatically on the earliest of the dates in 1 through 4 below:

1. The last day of an Eligibility Period which begins during a Qualifying Period (a) for which you are not credited with at least 400 hours, and (b) in which you no longer have at least 400 hours in your hour bank.
2. The date the Group Policy terminates.
3. The last day of the calendar month in which you cease to be a Member. However, your Insurance may be continued with payment of premium during a leave of absence if continuation of your Insurance under the Group Policy is required by the federal or state mandated family or medical leave act or law.
4. For Any Dependent:
   a. The last day of the calendar month in which you cease to be a Dependent.
   b. The date the Member's Insurance ends.
   c. The date you become covered under any other group dental plan, if the **Coverage Features** states that Insurance is not provided for Dependents who are covered under another group dental plan.
   d. For a Disabled Child, 90 days after we mail you a request for proof of Disabled Child status, if proof is not given.

DE.EN.12X

REINSTATEMENT

If your Insurance ends, you may become insured again as a new Member. However, the following will apply.

1. If Insurance ends because the Member fails to make a required premium contribution will apply.
2. The Benefit Waiting Period will apply if the Benefit Waiting Period applied on the date Insurance ended.
3. If your Insurance ends because you are on a federal or state mandated family or medical leave of absence, and you become a Member again immediately following the period allowed, your Insurance will be reinstated pursuant to the federal or state mandated family or medical leave act or law.

The Member and each Dependent must serve the remainder of the Benefit Waiting Period after becoming insured again.

DE.RE.04X

EXTENSION OF BENEFITS

We will extend Dental Benefits to cover the following services and supplies the Insured Person receives within 30 days after the date Insurance ends for any reason other than: (a) the Member's failure to make a required premium contribution or failure of your Employer to make premium contribution on your behalf; or (b) amendment to or termination of the Group Policy or termination of your Employer's participation under the Group Policy. This extension will apply only if Dental Benefits would have been paid had Insurance continued.

1. A fixed partial denture, crown, or onlay, if the Incurred Date is before Insurance ends.
2. Placement or modification of a non-orthodontic appliance, if the Incurred Date is before Insurance ends.
3. Root canal therapy, if the Incurred Date is before Insurance ends.

CONTINUATION AFTER DEATH OF MEMBER

Insurance for a Dependent will continue after the Member's death until the last day of the Eligibility Period which begins during a Qualifying Period (a) for which the Member is not credited with at least 400 hours, and (b) in which the Member no longer has at least 400 hours in the hour bank.

Insurance will not continue for a Dependent whose Insurance would end for any reason other than the death of the Member.

DE.EB.09X

FEDERAL COBRA

Federal COBRA means coverage pursuant to Section 4980B of the United States Internal Revenue Code requiring that Employers that employ 20 or more employees during the preceding calendar year give Qualified Beneficiaries the right to elect COBRA continuation after Insurance ends because of a Qualifying Event.

A. Definitions For This Section

Qualified Beneficiary means an Insured Person.

A Qualifying Event occurs when:

1. The Member dies;
2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer;
3. The Member (a) is not credited with at least 400 hours for a Qualifying Quarter; and (b) no longer has at least 400 hours in the hour bank.
4. The Member becomes divorced or legally separated from a Spouse;
5. The Member becomes entitled to receive Medicare benefits under Title XVIII of the Social Security Act;
6. The Child of a Member ceases to be a Dependent; or
7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed.

B. Electing COBRA Continuation

Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:

1. The date on which Insurance would otherwise end; and
2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.

C. Notice Requirements

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.

2. The Qualified Beneficiary must notify the Plan Administrator in writing within 60 days of Qualifying Event 4 or 6 above.

3. Each Qualified Beneficiary who, within the first 60 days of COBRA continuation due to Qualifying Event 2 or 3 above, is determined by the Social Security Administration to be disabled under Title II or XVI of the Social Security Act at the time of Qualifying Event 2 or 3 above must notify the Plan Administrator in writing within 60 days after the date disability is determined. If the Qualified Beneficiary ceases to be disabled, the Qualified Beneficiary must notify the Plan Administrator in writing within 30 days of the final determination date.

4. The Employer must give the Plan Administrator written notice within 30 days of Qualifying Event 1, 2, 3, 5, or 7.

5. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

D. Premium Requirements

Insurance continued under this provision will be retroactive to the date Insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the Premium Due Date thereafter. See **Coverage Features** for the COBRA Continuation Premium Rate.

E. COBRA Continuation Periods

1. 18-Month COBRA Continuation

Each Qualified Beneficiary may continue Insurance for up to 18 months after the date of Qualifying Event 2 or 3 above.

2. 29-Month COBRA Continuation

Each Qualified Beneficiary who within the first 60 days of COBRA continuation due to Qualifying Event 2 or 3 above, is determined by the Social Security Administration to be disabled under Title II or XVI of the Social Security Act at the time of Qualifying Event 2 or 3 above, may continue coverage for up to 29 months after the date of the Qualifying Event. All Insured Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

If you are a Dependent, you may continue Insurance for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6.

Note: The total period of COBRA continuation available in 1 through 3 above will not exceed 36 months.

4. COBRA Continuation For Certain Bankruptcy Proceedings

If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

F. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;

2. 31 days after the date the last period ends for which a required premium payment was made;

3. The last day of the COBRA continuation period.

4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVIII of the Social Security Act;

5. The first date on which the Qualified Beneficiary is: (a) covered under another group dental policy and (b) not subject to any preexisting condition limitation in that policy.

CALIFORNIA CONTINUATION OF COVERAGE (CAL-COBRA)

The California Continuation Benefits Replacement Act requires that Employers regularly employing at least 2 but less than 20 employees give Qualified Beneficiaries the right to elect continuation under the group benefit plan after Insurance ends because of a Qualifying Event.

A. Definitions For This Section

Employer means any employer that:

1. Employed at least 2 but fewer than 20 employees on at least 50 percent of its working days during the preceding calendar year;
2. Is not subject to Federal COBRA or Chapter 18 of the Employer Retirement Income Security Act (ERISA), 29 U.S.C. Section 1161 et seq.

Qualified Beneficiary means an Insured Person.

You will not be a Qualified Beneficiary if you:

1. Are entitled or become entitled to Medicare benefits under Title XVIII of the Social Security Act;
2. Are covered or become covered under another group dental benefit plan which does not have a preexisting condition exclusion or limitation;
3. Are covered, become covered or are eligible for coverage under Federal COBRA, Chapter 18 of ERISA or Chapter 6A of the Public Health Service Act;
4. Fail to meet the Notice Requirements below;
5. Fail to make a required premium payment for continuation of coverage or to satisfy other terms and conditions of the Group Policy.

Qualifying Event under this provision means coverage is lost when the following occurs:

1. The Member dies;
2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer;
3. The Member (a) is not credited with at least 400 hours for a Qualifying Quarter; and (b) no longer has at least 400 hours in the hour bank.
4. The divorce or legal separation of the covered Member from a Spouse;
5. The Child of a Member ceases to be a Dependent; or
6. With respect to a Dependent only, the Member becomes entitled to receive Medicare benefits under Title XVIII of the Social Security Act.

B. Electing CAL-COBRA Continuation

Each Qualified Beneficiary has the right to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing and deliver the written request by first-class mail or other reliable means of delivery to us within the 60-day period following the later of:

1. The date on which Insurance would otherwise end; and
2. The date you were sent notice of the right to CAL-COBRA.

C. Notice Requirements

1. All covered persons who are eligible to be Qualified Beneficiaries are required to notify us or the Employer if the Employer contracts to perform CAL-COBRA administrative services in writing of all Qualifying Events as specified in paragraphs (1), (4), (5) and (6) within 60 days of the date of the Qualifying Event. Failure to make the notification within the required 60 days will disqualify the Qualified Beneficiary from receiving continuation coverage pursuant to this article.

   The Employer must give us written notice within 31 days of Qualifying Event 2 or 3.

2. Each Qualified Beneficiary who, within the first 60 days of CAL-COBRA continuation due to Qualifying Event 2 or 3 above, is determined by the Social Security Administration to be disabled under Title II or XVI of the Social Security Act at the time of Qualifying Event 2 or 3 above must notify us or the Employer if the Employer has contracted to perform CAL-COBRA administrative services in writing within 60 days after the date of disability is determined. If the Qualified Beneficiary ceases to be disabled, the Qualified Beneficiary must notify us or the Employer in writing within 30 days of the final determination date.

3. Qualified Beneficiaries whose continuation coverage terminates under a prior group dental benefit plan, due to the termination of that plan, may continue their coverage under the Group Policy for the balance of the period that the Qualified Beneficiary would have remained covered under the prior group dental benefit plan including the requirements for election and payment.

   Continuation coverage shall terminate if the Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of premiums to, the Group Policy within 30 days of receiving notice of the termination of the prior group dental benefit plan.

4. Within 14 days of receiving notice of a Qualifying Event, we or the Employer, if the Employer has contracted to perform CAL-COBRA administrative services, must notify each Qualified Beneficiary in writing of the right to elect CAL-COBRA continuation. This information shall be sent to the Qualified Beneficiary's last known address.

D. Premium Requirements

Insurance continued under this provision will be retroactive to the date Insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium, and deliver the premium payment by first-class mail, certified mail or other reliable means of delivery to us or the Employer, if the Employer has contracted to perform CAL-COBRA administrative services, within 45 days after electing CAL-COBRA continuation. The initial premium must equal all premiums due. Failure to submit correct premiums within the 45-day period will disqualify the Qualified Beneficiary from continuation of coverage under CAL-COBRA. Thereafter, monthly premium is due on or before the Premium Due Date. See **Coverage Features** for the CAL-COBRA Continuation Premium Rate.

E. CAL-COBRA Continuation Periods

You may continue Insurance for up to 36 months after the date of any Qualifying Event.

F. When CAL-COBRA Continuation Ends

CAL-COBRA continuation ends under the Group Policy on the earlier of:

1. The date the Group Policy terminates;

2. 31 days after the date the last period ends for which a required contribution was made, or fails to satisfy other terms and conditions of the policy contract;

3. The last day of the CAL-COBRA continuation period;

4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVIII of the Social Security Act;

5. The first date on which the Qualified Beneficiary is: (a) covered under another group dental policy and (b) not subject to any preexisting condition limitation in that policy.

6. Individuals who are covered, become covered, or are eligible for coverage under Federal COBRA, Chapter 6A of the Public Health Service Act, or Chapter 18 ERISA.

7. A Qualified Beneficiaries fails to meet the requirements of notification of a Qualifying Event or election of continuation coverage within the specified time limits.

8. Qualified Beneficiary moves out of the insurer's service area, or the Qualified Beneficiary commits fraud or deception in the use of benefits.

G. Extension Of Coverage

1. Eligibility

A Member may continue benefits beyond the date coverage under CAL-COBRA would otherwise end if the Member terminates employment and at the time of termination the Member:

a. Has worked for the employer for at least 5 years;

b. Is at least 60 years of age; and

c. Elects to continue coverage for the Member and an eligible Spouse under CAL-COBRA.

The Qualified Beneficiary shall request in writing the extended continuation of coverage within 30 calendar days prior to the date CAL-COBRA is scheduled to end.

2. When Extended Coverage Ends

Extended coverage shall end on the earlier of:

a. The date the Qualified Beneficiary becomes 65 years of age;

b. The date the Qualified Beneficiary is covered under any other group dental benefit plan not maintained by their employer or any other dental health plan, even if that plan provides a lesser benefit;

c. The date the Qualified Beneficiary becomes entitled to Medicare under Title XVIII of the Social Security Act;

d. For a Spouse or former Spouse, 5 years following the date when continuation of coverage under CAL-COBRA was scheduled to end;

e. The date the Group Policy terminates; and

f. 31 days after the date the last period ends for which a required premium payment was made.

3. Premiums Requirements

Insurance continued under this provision will begin the day after the coverage under CAL-COBRA ends. The Qualified Beneficiary must pay the monthly premium for this extended coverage on or before the Premium Due Date.

CLAIMS

A. Filing A Claim

Claims should be filed on our forms. If we do not provide our forms within 15 days after they are requested, the claim may be submitted in a letter to us. The letter should describe the Dental Expenses for which the claim is made.

B. Time Limits On Filing Proof Of Loss

Proof Of Loss must be provided within 90 days after the Incurred Date of the Dental Expenses. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period. If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while you lack legal capacity.

C. Proof Of Loss

Proof Of Loss means written proof that you have Incurred Dental Expenses for which Dental Benefits are payable. Proof Of Loss must be provided at your expense. No Dental Benefit will be paid until Proof Of Loss is satisfied.

D. Documentation Of Proof Of Loss

At your expense, you must submit completed claim statements, your signed authorization for us to obtain information, and any other items we may reasonably require in support of your claim.

E. Investigation Of Claim

We may investigate your claim at any time.

At our expense, we may have a Dental Professional of our choice examine you and review X-rays.

We may deny or suspend payment of Dental Benefits if you or your Dental Professional fails to cooperate with a review or examination by the Dental Professional of our choice.

F. Payment Of Dental Benefits

1. Services Or Supplies Provided By A PPO Dental Professional

   We will pay all Dental Benefits directly to the Dental Professional providing the services or supplies.

   You may authorize us in writing to make payment to you immediately after Proof Of Loss is satisfied.

2. Services Or Supplies Provided By A Non-PPO Dental Professional

   We will pay all Dental Benefits directly to you immediately after Proof Of Loss is satisfied.

   You may authorize us in writing to make payment to the Dental Professional providing the services or supplies.

G. Right To Recover Overpayment

If we make a payment, and you are not entitled to all or a part of that payment, we may recover the payment from you or the Dental Professional. We may deduct the overpayment from future Dental Benefits.

H. Notice Of Decision On Claim

We will evaluate your claim promptly after we receive it. Within 30 days after we receive your claim we will send you: (a) a written decision on your claim; or (b) a notice that we are extending the period to decide your claim for an additional 15 days. If the extension is due to your failure to provide information necessary to decide the claim, the extended time period for deciding your claim will not begin until you provide the information or otherwise respond.

If we extend the period to decide your claim, we will notify you of the following: (a) the reasons for the extension; (b) when we expect to decide your claim; and (c) any additional information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.

b. Reference to the parts of the Group Policy on which our decision is based.

c. Reference to any internal rule or guideline relied upon in making our decision.

d. Information concerning your right to receive an explanation of the scientific or clinical judgement we relied upon to exclude Dental Expenses for services or supplies that are experimental or investigational or are not necessary or accepted according to generally accepted standards of dental practice.

e. A description of any additional information needed to support your claim.

f. Information concerning your right to a review of our decision.

g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA if your claim is denied on review.

I. Review Procedure

If all or part of a claim is denied, you may request a review. You must request a review in writing within 180 days after receiving notice of the denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your request for review. There will be no charge for such copies. You may request the names of dental experts who provided advice to us about your claim.

The person conducting the review will be someone other than the person who denied the claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based on the judgment of a Dental Professional, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the Dental Professional who made the original judgement and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request. Within 60 days after we receive your request for review we will send you a written decision on review.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.

b. Reference to the parts of the Group Policy on which our decision is based.

c. Reference to any internal rule or guideline relied upon in making our decision.

d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.

e. Information concerning your right to receive an explanation of the scientific or clinical judgement we relied upon to exclude Dental Expenses for services or supplies that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of dental practice.

f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

The Group Policy does not provide voluntary alternative dispute resolution options.

DE.CL.39

ALLOCATION OF AUTHORITY

Except for those functions which the Group Policy specifically reserves to the Policyholder, we have full and exclusive authority to control and manage the Group Policy, to administer claims, and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy.

Our authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;
2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it;
3. The right to determine:
    a. Eligibility for Insurance;
    b. Entitlement to benefits;
    c. Amount of benefits payable;
    d. Sufficiency and the amount of information we may reasonably require to determine a, b, or c above.

Subject to the review procedures of the Group Policy, any decision we make in the exercise of our authority is conclusive and binding.

DE.AL.01

TIME LIMITS ON LEGAL ACTIONS

No action at law or in equity may be brought until 60 days after you have given us Proof Of Loss. No such action may be brought more than three years after the earlier of:

1. The date we receive Proof Of Loss; and
2. The end of the period within which Proof Of Loss is required to be given.

DE.TL.01

INCONTESTABILITY PROVISIONS

A. Incontestability Of Insurance

Any statement made to obtain Insurance is a representation and not a warranty.

No misrepresentation will be used to reduce or deny a claim unless:

1. The Insurance would not have been approved if we had known the truth; and
2. We have given you or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

After Insurance has been in effect for two years, we will not use a misrepresentation to reduce or deny a claim, unless it was a fraudulent misrepresentation.

B. Incontestability Of Group Policy

Any statement made by the Policyholder or Employer to obtain the Group Policy is a representation and not a warranty.

No misrepresentation by the Policyholder or Employer will be used to deny a claim or to deny the validity of the Group Policy unless:

1. The Group Policy would not have been issued if we had known the truth; and
2. We have given the Policyholder or Employer a copy of a written instrument signed by the Policyholder or Employer which contains the misrepresentation.

The validity of the Group Policy will not be contested after it has been in force for two years, except for nonpayment of premiums or fraudulent misrepresentations.

DE.IN.01

DEFINITIONS

Active Work and Actively at Work mean performing the material duties of your own occupation at your Employer's usual place of business.

Contributory means you pay all or part of the premium for your insurance.

Dental Professional means any of the following who is acting within the scope of the license:

1. A doctor of dental medicine (D.M.D.);
2. A doctor of dental surgery (D.D.S.);
3. A dental hygienist; or
4. A denturist.

Dental Professional does not include: the Member; or the spouse, brother, sister, parent or child of either the Member or the Member's Dependent.

Eligibility Waiting Period means the period you must be a Member before you become eligible for insurance. See **Coverage Features**.

Group Policy means the group dental insurance policy issued by us to the Policyholder and identified by the Group Policy Number.

Incurred Date means, with respect to a Dental Expense, the date the services or supplies are provided to you, except:

1. An appliance or modification of an appliance is incurred on the date the impression is made;
2. A crown, bridge or gold restoration is incurred on the date the tooth or teeth are prepared; and
3. Root canal therapy is incurred on the date the pulp chamber is opened.

Injury means an injury to your body.

Insurance means insurance under the Group Policy.

Insured Person means the Member or any Dependent who is insured under the Group Policy.

Negotiated Fee Schedule means the schedule of charges for dental services and supplies which has been agreed upon by the preferred provider organization and the PPO Dental Professionals who are participating in the preferred provider organization.

Noncontributory means the Policyholder or Employer pays the entire premium for your Insurance.

Non-PPO Dental Professional means a Dental Professional who is not participating in the preferred provider organization shown in the **Coverage Features**.

Periodontal Splint means any appliance designed to retain teeth in position, and includes multiple abutments for fixed bridgework.

Plan Administrator means the person designated by the Employer to maintain the coverage under the Group Policy.

PPO Dental Professional means a Dental Professional who is participating in the preferred provider organization shown in the **Coverage Features**.

Prior Plan means your Employer's group dental plan in effect on the day before the effective date of your Employer's coverage under the Group Policy and which is replaced by the Group Policy.

Reasonable and Customary Charge means the lesser of:

1. The Dental Professional's usual charge for the same services or supplies in the absence of dental insurance coverage; and
2. The charge customarily billed to private patients for the same or similar dental services or supplies by Dental Professionals with similar training and experience in the same Geographically Significant Area. Geographically Significant Area means an area which we determine is large enough to provide a representative base of charges for the same or similar dental services or supplies.

The Reasonable and Customary Charge is determined every six months. The Reasonable and Customary Charge is based upon national and regional claims statistics which compile billed fees that Dental Professionals customarily charge for dental services and supplies.

Sickness means your sickness, illness, or disease.

Spouse means:

1. A person to whom you are legally married; or
2. Your Domestic Partner. Your Domestic Partner means an individual recognized as such under California state law.

For purposes of insurance under the Group Policy, Spouse does not include a person who is a full-time member of the armed forces of any country or a person from whom you are divorced or legally separated or from whom you have terminated a Domestic Partner relationship.

DE.DF.01

ERISA INFORMATION AND NOTICE OF RIGHTS

The following information and notice of rights and protections is furnished by the Plan Administrator as required by the Employee Retirement Income Security Act of 1974 (ERISA).

A. General Plan Information

The General Plan Information required by ERISA is shown in the **Coverage Features**.

B. Preferred Provider Organization

If the Group Policy includes a preferred provider organization, a separate list of such providers will be made available automatically and without charge.

C. COBRA Continuation Of Dental Coverage.

If you or your insured dependents (including spouse), lose coverage as a result of a qualifying event, you or your dependants may elect to continue dental overage. Those electing to do so may have to pay for such coverage. The summary plan description and Group Policy contain the complete COBRA continuation provisions.

D. Statement Of Your Rights Under ERISA

1. Right To Examine Plan Documents

You have the right to examine all Plan documents, including any insurance contracts or collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. These documents may be examined free of charge at the Plan Administrator's office.

2. Right To Obtain Copies Of Plan Documents

You have the right to obtain copies of all Plan documents, including any insurance contracts or collective bargaining agreements, a copy of the latest annual report (Form 5500 Series), and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies.

3. Right To Receive A Copy Of Annual Report

The Plan Administrator must give you a copy of the Plan's summary annual financial report, if the Plan was required to file an annual report. There will be no charge for the report.

4. Right To Review Of Denied Claims

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have the right: a) to know why this was done; b) to obtain copies of documents relating to the decision, without charge; and c) to have your claim reviewed and reconsidered, all within certain time schedules.

E. Obligations Of Fiduciaries

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

F. Enforcing ERISA Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

G. Plan And ERISA Questions

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

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

ERISA.90.04