COVERAGE PROVIDED BY
YOUR GROUP'S DENTAL POLICY WITH

HORIZON HEALTHCARE DENTAL, INC.

In this booklet, You will find the important features of Your Group Dental Policy. Please read this booklet carefully so that You are familiar with Your dental care benefits. If You need more information, see Your Group Enrollment Official or call the Horizon Healthcare Dental, Inc.'s customer Service Department at (800) 961-2221, or write to Horizon Healthcare Dental, Inc. at 3 Penn Plaza, PP03Q, Newark, New Jersey 07105-2200.

This booklet is only a description of Your benefits. The Policy held by the Group contains all the terms and provisions of the Contract between the Group and Horizon Healthcare Dental, Inc. In the event of a conflict between the Policy and this booklet, the Policy will prevail.

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IMPORTANT NOTICE

In order to be eligible, the Covered Services provided must be Necessary Dental Services and must be rendered by Your Primary Care Dentist or authorized by Us to be provided by a Specialty Care Dentist, except for Emergency Services. Out-of-Network Services are not Covered Services.

Some Covered Services require a Copayment.

CERTIFICATE OF COVERAGE

Horizon Healthcare Dental, Inc. certifies that coverage is provided according to the Group Contract for each Covered Subscriber.

Covered Subscriber: You are eligible to become covered under the Group Contract if You are in an Eligible Class and meet the requirements in the Eligibility Classification section of the Certificate. The Probationary Period section states when You may become covered for each coverage and the How to Enroll section states how You may become covered for each coverage. Your coverage will end when the rules in When Your Coverage Ends section so provide. The available Coverage and the extent of coverage are described in the Certificate.

The Certificates of Coverage replaces any older certificates issued to You for the Coverage described in this Certificate.

GENERAL INFORMATION

A. SUBSCRIBERS

All Employees in any Eligibility Classification(s) below may subscribe to this Policy. Each of them and their Dependents is Eligible for coverage under this Policy as stated in Section B if, on or after the Effective Date, the Employee has completed the appropriate probationary period, if any, and has, along with any Dependents, satisfied the Underwriting Requirements, as determined by Horizon Healthcare Dental, Inc.

B. ELIGIBILITY CLASSIFICATION(s)

All Active, Full-time Employees who reside in the State of New Jersey and are not covered under any other Alternate Dental Plan offered by the Policyholder.

C. PROBATIONARY PERIOD

Coverage shall be effective for eligible Employees on the later of the Effective Date or on the first day of the calendar month following the satisfaction of any Probationary Period required by the Group Contract.

D. THE HORIZON DENTAL CHOICE NETWORK

Horizon Healthcare Dental, Inc. has established and administers a network of Primary Care Dentists and Specialty Care Dentists who provide Covered Services subject to the exclusions, limitations, conditions and other terms of Your Policy.

Services are provided through the Horizon Dental Choice Network. You and each of Your Dependents must choose a Primary Care Dentist from a list provided by Horizon Healthcare Dental, Inc. Your choice of Primary Care Dentist may be changed effective on the first day of any month by giving Horizon Healthcare Dental, Inc. 15 days notice.

For certain dental care, the Primary Care Dentist may recommend, subject to Horizon Healthcare Dental, Inc.' s approval, care by a Specialty Care Dentist. A Specialty Care Dentist will provide Members with Specialty Dental Services which are authorized and approved by Horizon Healthcare Dental, Inc.

E. HOW TO ENROLL

You may enroll for dental benefits by completing an enrollment form. If You enroll Your Dependents when You first become eligible, their coverage will become effective on the same date as Yours. If You do not apply for coverage for Yourself or Your Dependents when You first become eligible, You must wait for the next open enrollment period to enroll, subject to Our Underwriting Requirements.

F. WHEN YOUR COVERAGE ENDS

Coverage for You and Your Dependents ends when You no longer meet the eligibility requirements for this Policy, or when Our contract with the Group ends. Coverage for a Dependent will also end when that Dependent no longer meets the Eligibility requirements.

We will terminate Your coverage immediately if You or any of Your Dependents have engaged in fraud or intentionally made any false statement in Your enrollment form or in any other claim for benefits under Your Policy.

G. TYPES OF ENROLLMENT COVERAGE

You may enroll under one of the following types of coverage:

1. **Single Coverage.** Coverage under this Policy for You only.
2. **Parent and Child(ren) Coverage.** Coverage under this Policy for You and Your Child Dependent(s) only.
3. **Husband and Wife Coverage.** Coverage under this Policy for You and Your Spouse only.
4. **Family Coverage.** Coverage under this Policy for You,Your Spouse, and one or more of Your Child dependent

H. CHANGE IN TYPE OF COVERAGE

If You gain or lose a member of Your family or whenever someone covered under this Policy changes eligibility status, You should check this booklet to see if Your type of coverage should be changed. This can happen for many reasons: for example, through the birth or adoption of a Child or the divorce or death of a Spouse.

If You want to change Your type of coverage, see Your Enrollment Official. If You have Single coverage, You must submit an enrollment form to change to any other type of coverage. If You marry, You should arrange to enroll Your Spouse within 60 days from the date of Your marriage, in order for Your Spouse's coverage to become effective as soon as he or she is eligible.

Coverage for Your newborn Child Dependent will be effective at birth if, within 31 days, You enroll that Child Dependent.

If You fail to enroll Your newborn Child within 31 days, but enroll him or her within 90 days after the birth, coverage will be effective on the first day of the month after the date the enrollment form is received by Us.

I. IF YOU ARE DISABLED WHEN COVERAGE ENDS

If You are Totally Disabled and hospitalized on the date coverage for Your Group ends, We will provide Covered Services which began before the date the Policy ended and continued after that date, but only up to 30 days from the day the Policy ends or You are no longer Totally Disabled, whichever occurs first.

J. EXTENSION OF COVERAGE

Coverage will be extended for services provided within 30 days after Your coverage ends, but only for the following Covered Services:

1. an appliance, or alteration of one for which a final impression was made while You were a Subscriber;
2. a crown, bridge inlay or onlay for which the tooth was prepared while You were a Subscriber;
3. root canal therapy for which the pulp chamber was opened while You were a Subscriber.

DEFINITIONS

This section defines certain important words used in this booklet. The meaning of each defined word (when the first letter is capitalized) is governed by its definition in this section.

ACCIDENTAL INJURY / ACCIDENT. A sudden or unforeseen result of an event, occurrence, or trauma which causes injury to the mouth and is definite as to time and place.

ALLOWANCE. An amount which We determine is a reasonable charge for a Covered Service, and on which We base our Payment.

ALTERNATE DENTAL PLAN. A dental benefit plan option offered by the Policyholder in lieu of this Policy.

BENEFIT YEAR. The twelve-month period starting on January 1 and ending on December 31 of each year. A Member's first and last Benefit Year may be less than a full year. The first Benefit Year begins on the Member's coverage effective date; the Member's Benefit Year ends when he or she is no longer covered under this Policy. Covered Services must be initiated and rendered during this period in order to be eligible for Payment.

CHILD

1. A Child described below who has not yet attained termination age as determined by the Group Contract, is unmarried, is wholly Dependent upon You for support and maintenance, does not have and is not eligible for dental health coverage through his or her place of employment, is classified as a Dependent under federal tax law, and is:

    a. a natural born Child or Stepchild of You or Your Spouse who resides in New Jersey. However, a natural born Child of You or Your Spouse who is born out of wedlock must reside with You. We may waive this residency requirement if a court decree specifies that You are responsible for the Child's dental care expenses. However, the Child must reside in New Jersey;
    b. a legally adopted Child of You or Your Spouse who resides in New Jersey;
    c. a legal ward of You or Your Spouse who resides in New Jersey with You in a regular Parent-Child relationship.

2. A Child otherwise defined in paragraph(s) 1a., b., or c. above but who has attained the termination age as determined by the Group Contract and who We determine is incapable of self-sustaining employment by reason of mental

or physical handicap and who became so incapable prior to attaining the termination age as determined by the Group Contract shall be considered a Child under this Policy.

Note: proof of the handicap as Determined by Us must be submitted to Us within 31 days of the last day of the calendar month in which the Child attained the termination age determined by the Group. Thereafter, proof need only be provided once every 2 years.

3. A Child otherwise defined in paragraph(s) 1a., b., or c. above but who has attained the termination age as determined by the Group Contract and who We determine is a full-time student at an accredited institution of higher learning shall be considered a Child under this Policy until he or she attains a specified age as determined by the Group Contract.

4. A Child born to Your Child Dependent is not considered a Child under this Policy.

Proof of support, adoption, handicap, residency, student status, and all other matters pertaining to Eligibility as a Child Dependent, as determined by Us, must be submitted to Us when requested.

COINSURANCE. The percentage amount of Our Allowance that We pay for certain Covered Services.

COPAYMENT. A specified dollar amount or percentage which You must pay at the time certain Covered Services are rendered before any Payment will be made for those Covered Services. Your Copayment amounts are indicated in the attached schedule.

COVERED SERVICE. Necessary Dental Services and supplies recommended, arranged or rendered by a Primary Care Dentist, or by a Specialty Care Dentist, if authorized by Us, or by a Dentist authorized by Us, for which We will provide Payment.

DENTIST. An individual licensed to practice dentistry and acting within the scope of his or her dental licensure.

DEPENDENT. A Spouse or Child whom the Subscriber enrolls for coverage.

EMERGENCY SERVICES. Dental services for palliative treatment furnished by a Dentist. The services must be needed to relieve pain or to prevent worsening of a dental condition that would be caused by further delay.

EXPERIMENTAL OR INVESTIGATIONAL. Dental services or supplies which We determine are:

1. not of proven benefit for the particular diagnosis or treatment of the patient's particular dental condition; or
2. not generally recognized by the dental community as effective or appropriate for the particular diagnosis or treatment of the patient's dental condition; or
3. Notwithstanding the above, We may impose additional criteria to determine whether an Experimental or Investigational service has been provided.

This Policy will not cover any technology if such technology is obsolete or ineffective and is not used generally by the dental community for the particular diagnosis or treatment of a patient's particular dental condition.

FULL-TIME. Permanently employed by the Employer for an average of 30 or more hours per week.

HDC NETWORK. All Primary Care Dentists and Specialty Care Dentists who have entered into an agreement with Horizon Healthcare Dental, Inc. to provide Covered Services to Members.

INDIVIDUAL. A person who may be or is Eligible for coverage under this Policy.

IN-NETWORK DENTIST. A Dentist who has an agreement with Us to furnish Covered Services to Members.

IN-NETWORK SERVICES. Dental services provided or coordinated by an In-Network Dentist. The term may also refer to a level of coverage or Payment provided under this Policy.

MEMBER. Any enrolled Employee and his or her enrolled Dependent(s).

NECESSARY DENTAL SERVICES. Services or supplies provided by a Dentist that are determined by Our professional staff to be:

1. appropriate for the symptoms and diagnosis or treatment of a dental condition, illness, disease, or injury;
2. provided for the diagnosis or the direct care and treatment of a dental condition, illness, disease or injury;
3. in accordance with the accepted dental practices in the community at the time; and

4. the most appropriate supply or level of service that can be provided under the circumstances.

5. Notwithstanding the above, We may impose additional criteria to determine whether a Necessary Dental Service has been provided.

We will determine whether a particular dental service is a Necessary Dental Service only for the purpose of determining whether such services are Covered Services and not for the purpose of practicing dentistry or determining a course of treatment.

OUT-OF-NETWORK DENTIST. A Dentist who does not have an agreement with Us to furnish or coordinate Covered Services to Members.

PAYMENT. The amount We will pay a Dentist for Covered Services.

PERMANENT PART-TIME. Permanently employed by the Employer for an average of fewer than 30 hours per week, but no less than 20 hours.

POLICY. The Group application, the enrollment forms, the insurance policy and all amendments to it.

PRE-EXISTING CONDITION. A dental condition which exists 6 months before the date on which coverage begins for a Member and for which he or she either obtained a diagnosis or received treatment, or reasonably should have obtained a diagnosis or received treatment.

PRIMARY CARE DENTIST. A Dentist who has agreed with Us to provide Covered Services.

PROBATIONARY PERIOD. A period described in Schedule A of the Group Application during which an Employee is not Eligible for coverage.

RETIREE. A person who has satisfied the requirements for retirement from employment with the Employer.

SPECIALTY CARE DENTIST. A Dentist who holds a specialty license in one or more approved dental specialties and has agreed with Us to provide covered specialty dental services.

SPOUSE. The person to whom You are legally married.

SUBSCRIBER. An Employee who is enrolled in this Policy in accordance with Schedule A of the Group Application.

TOTALLY DISABLED (or Total Disability), The condition of an Employee being unable to perform any occupation for which the Employee is qualified or may reasonably become qualified by training, education or experience.

UNDERWRITING REQUIREMENTS. The requirements Horizon Healthcare Dental, Inc. determines to be appropriate for making, maintaining and administering this policy and coverage for Members and their Dependents.

WE, US, OUR. Horizon Healthcare Dental, Inc.

YOU, YOUR, YOURS. An employee who is eligible for enrollment through the Group.

COVERED SERVICES

A. PAYMENT FOR COVERED SERVICES

Non-Emergency Services. Payment is made directly to the Primary Care Dentist and the Specialty Care Dentist. Payment by Us does not include any Copayment, as applicable. Any Copayments or Deductibles You must pay are indicated in the attached schedule.

Emergency Services. Emergency Services are covered at 50% of Our Allowance, up to a maximum of $100.00 per emergency if Emergency Services are rendered by other than Your Primary Care Dentist. Benefits for Emergency Services may be paid either directly to an MDC network Dentist, or to You.

B. SCHEDULE OF SERVICES

1. SCHEDULE OF BASIC DENTAL SERVICES - PART A

a. <u>VISITS AND EXAMS</u>

- Office visit - oral exam ..... No Charge
- Emergency palliative treatment ..... No Charge
- Prophylaxis, treatment (*includes scaling; polishing*) ..... No Charge
- Topical application of fluoride ..... No Charge
- Study models ..... No Charge
- Oral hygiene instruction ..... No Charge
- Sealants ..... No Charge

b. <u>X-RAYS</u>

- Bitewing X-rays ..... No Charge
- Entire series / Panoramic ..... No Charge
- Periapical X-rays ..... No Charge
- Intra-oral, occlusal view, maxillary or mandibular ..... No Charge
- Extra-oral upper or lower jaw ..... No Charge

c. <u>ENDODONTICS</u>

- Pulp vitality test ..... No Charge
- Pulp capping ..... No Charge
- Pulpotomy ..... No Charge
- Apexification ..... No Charge
- Rubber dam isolation ..... No Charge
- Root canal therapy
  - Anterior ..... No Charge
  - Bicuspid ..... No Charge

d. <u>RESTORATIONS AND REPAIRS</u>

- Amalgam restorations
  - 1 surface ..... No Charge

2 surfaces ..... No Charge
3 or more surfaces ..... No Charge

· Resin restorations (*other than for molars*)
1 surface ..... No Charge
2 surface ..... No Charge
3 or more surfaces ..... No Charge

· Retention pins ..... No Charge
· Stainless steel crowns ..... No Charge
· Resin temporary crowns ..... No Charge
· Recementing inlays, crowns, bridges, and space maintainers ..... No Charge
· Tissue conditioning for dentures ..... No Charge

e. PERIODONTICS

· Emergency treatment (*abscess, acute periodontitis, etc.*) ..... No Charge
· Subgingival curettage ..... No Charge
· Scaling and root planing ..... No Charge

f. ORAL SURGERY - Includes local anesthetics and routine post-operative care

· Extractions, uncomplicated ..... No Charge
· Surgical removal of erupted tooth ..... No Charge
· Surgical removal of impacted tooth (*soft tissue*) ..... No Charge
· Excisions of hyperplastic tissue ..... No Charge
· Excision of pericoronal gingiva ..... No Charge
· Incision and drainage of abscess ..... No Charge
· Crown exposure to aid eruption ..... No Charge
· Removal of foreign body from soft tissue ..... No Charge
· Suture of soft tissue injury ..... No Charge

BASIC SERVICES - PART B

g. RESTORATIONS

· Metallic / porcelain / resin inlays*
1 surface ..... No Charge
2 or more surfaces ..... No Charge

· Metallic onlays*
1 surface ..... No Charge
2 or more surfaces ..... No Charge

· Crowns (*including build-ups when necessary*)
Acrylic ..... $50 Copayment
Acrylic with metal ..... $145 Copayment
Porcelain with metal ..... $150 Copayment
Full metal crown ..... $150 Copayment

Gold onlay or ¾ crown ..... $140 Copayment
Stainless steel crown (primary) ..... $30 Copayment

Stainless steel crown (permanent) .....$30 Copayment

· Artificial tooth replacement
  Tru-pontic type .....$150 Copayment
  Porcelain to metal .....$150 Copayment
  Plastic processed to gold.....$140 Copayment
· Dentures
  Complete upper denture.....$160 Copayment
  Complete lower denture.....$170 Copayment
  Partial upper/lower (each).....$165 Copayment
· Denture and partial adjustments..... No Charge
· Denture and partial repairs.....$20 Copayment
· Adding teeth to existing partial or denture.....$30 Copayment
· Office reline.....$35 Copayment
· Laboratory reline .....$45 Copayment
· Recementation
  Inlay..... No Charge
  Crown ..... No Charge
  Bridge ..... No Charge
· Habit appliances (bruxism, etc.) ..... No Charge

- Also: Porcelain / ceramic / composite / resin

h. **<u>SPACE MAINTAINERS</u>** - Includes all adjustments within 6 months after insertion
· Fixed unilateral or bilateral..... No Charge
· Removable unilateral or bilateral..... No Charge
· Removable appliance to correct habits ..... No Charge
· Fixed or cemented appliance
(for correction of harmful habits) ..... No Charge

i. **<u>OTHER PROCEDURES</u>**
Broken appointments (less than 24-hour notice) .....$25 Copayment
Emergency visit after normal visiting hours .....$25 Copayment

2. SCHEDULE OF SPECIALTY DENTAL SERVICES
PART A

a. **<u>ENDODONTICS</u>** - Includes local anesthetics where necessary
· Apexification ..... No Charge
· Apicoectomy (per tooth) - first root..... No Charge
· Apicoectomy (per tooth) - each additional root ..... No Charge
· Retrograde Filling..... No Charge
· Root Amputation ..... No Charge
· Hemisection..... No Charge

b. **<u>ORAL SURGERY</u>** - Includes local anesthetics where necessary and post-operative care
· Removal of residual root..... No Charge
· Removal of odontogenic cyst ..... No Charge

· Closure of oral fistula ..... No Charge
· Removal of foreign body from bone..... No Charge
· Sequestrectomy..... No Charge
· Frenectomy ..... No Charge
· Transplantation of tooth or tooth bud ..... No Charge
· Alveolectomy / Alveoplasty ..... No Charge
· Removal of exostosis..... No Charge
· Sialolithotomy; removal of salivary calculus..... No Charge
· Closure of salivary fistula..... No Charge

c. **PERIODONTICS**
· Gingivectomy or Gingivoplasty - per quadrant ..... No Charge
· Gingivectomy or Gingivoplasty - per tooth ..... No Charge
· Gingival flap procedure - per quadrant..... No Charge
· Free soft tissue graft ..... No Charge
· Occlusal adjustment (*other than with an appliance or by restoration*)
Limited ..... No Charge
Entire mouth ..... No Charge

SPECIALTY SERVICES - PART B

d. **ENDODONTICS** - Includes local anesthetics where necessary.
· Complex Molar Root Canal Therapy..... No Charge
(*including X-rays and cultures but excluding final restoration*)

e. **INTRAVENOUS SEDATION AND GENERAL ANESTHESIA**..... No Charge

f. **ORAL SURGERY** - Includes local anesthetics where necessary and post-operative care
· Surgical removal of impacted tooth
Partially bony..... No Charge
Completely bony ..... No Charge

g. PERIODONTICS

- Osseous surgery including gingivectomy, soft tissue grafts, and post-operative care
  (*including flap entry and closure*)..... No Charge
- Guided Tissue Regeneration (GTR)
  (*including related procedures*) ..... No Charge

h. ORTHODONTIC PROCEDURES

- Orthodontic appliances and treatment
  (*per normal 24-month banded case)*.....Copayment of $2,200 Children/adult

EXCLUSIONS AND LIMITATIONS

A. We will not provide any benefit that is not a necessary Dental Service.

B. We will not provide any benefit or supplies which were not prescribed, arranged, coordinated, rendered or approved by the Primary Care Dentist, or by a Specialty Care Dentist, if the services provided by the Specialty Care Dentist were not duly authorized and approved by Horizon Healthcare Dental, Inc.; except in the case of Emergency Services.

C. We will not provide any benefit for dental services by an Out-of-Network Dentist unless specifically approved or authorized by Horizon Healthcare Dental, Inc.

D. If a service is provided under any law or governmental program, We will not provide that service under this program. This exclusion applies no matter where the law is in effect and whether or not You assert Your right to that coverage.

E. We will not provide any benefit for treatment of any condition, disease, illness or injury that is covered under any workers' compensation law, the Federal Employer's Liability Act, the Longshoremen's and Harbor Workers' Compensation Act, the Jones Act, no-fault automobile insurance or similar law, until You have exhausted all of the benefits available under these laws. This applies even if (1) You do not claim benefits under the above laws or policies, or (2) after any of the above benefits are paid, You repay them because You recovered that money in a lawsuit or other proceeding.

F. We will not provide any benefit for prescription and non-prescription drugs and medications.

G. We will not provide any benefit to any person in the armed forces of any government other than for duty of 30 days or less.

H. We will not provide any benefit if it is usually provided without charge to the patient. Even when charges are billed, they are excluded from coverage if they are not usually collected when there is no insurance coverage.

I. We will not provide any benefit for cosmetic services. Facing on crowns or pontics that are posterior to the second bicuspid will always be considered cosmetic. This does not apply if the ervice is needed as a result of an Accidental Injury sustained while the patient is a Member.

J. We will not provide any benefit for replacement or modification of a partial or full removable denture, a removable bridge or fixed bridgework, or for adding teeth to any of these, or for a replacement or modification of a crown, inlay or onlay, within 5 years after that denture, bridge, bridgework, crown, inlay or onlay was installed.

K. All of the following services and materials are excluded from coverage:

- Implantology
- Educational services, such as oral hygiene or dietary instructions
- Services in connection with plaque control programs
- Duplicate space maintainers
- Gold foil restorations
- Services performed by a dental department or clinic of an employer, labor union, or similar group
- Any services by a Dentist which are not specifically listed as Covered Benefits under this program
- Bone grafts
- Services to diagnose or treat disease of the temporomandibular joint or craniomandibular disorders
- Services provided by an immediate relative.

L. In addition, the following apply:

- If there is more than one way of treating the same condition which carry different fees, We will not pay more than the lower fee.

However, if the method which has the higher fee is the only way of treating the condition and We have approved it, We will pay the higher fee.

- If an eligible person transfers from one Dentist to another while under treatment, or if more than one Dentist performs services for a dental procedure, We will not pay more than the amount that would be paid if only one Dentist had performed all of the services.

GENERAL PROVISIONS

A. RELEASE OF INFORMATION

Each Member agrees, as a condition of coverage, that any Dentist or entity having information relating to an illness or injury for which benefits are claimed under this Policy may furnish to Us, upon Our request, any such information (including copies of records).

Any information received by Us shall be kept confidential and, except as reasonably necessary in connection with the administration of the Policy, will not be disclosed without the Member's consent.

Use of this information in the aggregate based upon dental records of Member where no individual person is identified will not require consent. We have the right to require authorization from the Member's Dentist before releasing dental information.

B. NOTICE OF GRIEVANCE

We will not be liable under Your Policy unless You or Your Primary Care Dentist or Your Specialty Care Dentist provide proper notice that Covered Services have been performed.

Written notice must be given not later than 1 year from the date Covered Services were performed for You or Your Dependent. The notice must include information necessary for Us to determine benefits. Failure to give Us notice within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible.

Send Your Notice of Grievance to Horizon Healthcare Dental, Inc., 3 Penn Plaza East, PP03Q, Newark, New Jersey 07105-2200, attention: Customer Service.

C. GRIEVANCE PROCEDURE

You or Your representative may ask Us to reconsider any Dental Service or related reimbursement for which You believe benefits have been denied in error, based on the Exclusions and Limitations and General Exclusions in Your group Policy. If You wish to pursue legal action against Us, You must do so within 12 months from the date You receive the notice of denial. Your appeal should be made in writing and include the following:

- Your name and address
- Name and address of patient (if not You)
- The identification number as it appears on the ID card

- Date of service
- Name and address of Dentist
- Why You think our decision should be reconsidered

Send Your request to Horizon Healthcare Dental, Inc., 3 Penn Plaza East, PP03Q, Newark, New Jersey 07105-2200, attention: Customer Service.

You have the right to see any documents that affect Your appeal. A copy of the Policy is available from Your Group. You can get a copy of other material relative to Your appeal from Us. In some cases, written authorization from the Dentist to release certain information will be necessary. You will be informed if We need this permission.

When Your grievance is received, the Dental Service or related reimbursement will be researched and reviewed. We will notify You in writing of the decision on Your appeal within 60 days after Your appeal is received. However, special circumstances, such as delays by You or the Dentist in submitting necessary information may require an extension of this 60-day period.

If legal action is brought against Us for a Dental Service or related reimbursement that has been wholly or partially denied, the action must be brought within 12 months of the first denial, or if the Dental Service or related reimbursement has been appealed, within 12 months of the denial of the appeal.

D. COORDINATION OF BENEFITS

Almost all group insurance programs provide for coordination of benefits. A program without such a provision is automatically the primary program whenever its benefits are duplicated. For programs that do have this provision, the following rules determine which one is the primary program:

- If You are the patient, this program is primary. If Your Spouse is the patient and is covered under a program of his or her own, then that program is the primary program.

- If a Child Dependent is the patient and is covered under both parents' programs, the program of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the program in effect longer is primary. If the other program does not have this birthday rule but instead has a rule based on the gender of the parent, then the father's program is primary.

If the parents are separated or divorced, benefits will be determined as follows:

- The program of the parent who has custody is primary.

- If the parent with custody has remarried, and the Child is also covered as a Dependent under the step-parent's program, the parent with custody will pay first, the step parent's program second and the other parent third. If a court decree or agreement between the parents specifies which parent is to be responsible for the Child's dental care expenses and that parent's program is knowledgeable of the decree, then that parent's program is primary.

If none of the above rules applies, the program that has covered the patient for the longer period is the primary policy.

E. APPLICABLE LAW

This Policy is administered according to the laws of New Jersey.

ORTHODONTIC BENEFITS RIDER

This Policy provides the following benefits for orthodontic treatment to those described below as Eligible.

A. ELIGIBLE MEMBERS

This rider provides for partial payment for Orthodontic Procedures performed by an HDC Specialty Care Dentist for a Child Dependents age 19 or less.

Coverage under this rider ends on the date the Child Dependents ceases to be a Member.

B. DEFINITIONS

These terms have the following meanings when used in this rider:

Amounts. The total estimated benefits to be paid to the Specialty Care Dentist in installments over the estimated duration of the Orthodontic Treatment Plan.

Orthodontic Procedure. Use of active appliances to move teeth, to correct:

1. faulty position of teeth (malposition); or
2. abnormal bite (malocclusion).

Orthodontic Treatment Plan. A Specialty Care Dentist's report, on a form approved by Horizon Healthcare Dental, Inc. that:

1. states the class of malocclusion or malposition;
2. recommends and describes needed treatment by Orthodontic Procedures;
3. estimates the duration of the treatment;
4. estimates the total charge for the treatment; and
5. includes cephalometric x-rays, study models and any other supporting evidence that Horizon Healthcare Dental, Inc. may reasonably require.

C. COVERED SERVICES

Covered Services are those provided in connection with the Orthodontic Procedures performed on persons described in Section A of this rider and described in an Orthodontic Treatment Plan.

An orthodontic service is a Covered Service if all of these conditions are met:

1. it is made for a service or supply furnished in connection with an Orthodontic Procedure and before the estimated duration shown in the Orthodontic Treatment Plan expires;

2. an active appliance for that Orthodontic Procedure is inserted while the person was covered;

3. the Orthodontic Procedure is needed to correct one of these conditions:

    a. vertical or horizontal overlap of upper teeth over lower teeth (overbite or overjet),
    b. faulty alignment (either frontwards or backwards) of the upper and lower arches with each other,
    c. cross-bite; and

4. the service or supply is made part of an Orthodontic Treatment Plan that, before the Orthodontic Procedure is performed, has been:

    a. sent to Horizon Healthcare Dental, Inc. for review, and
    b. returned by Horizon Healthcare Dental, Inc. to the Dentist showing authorization for the service and amounts of coverage.

The Member is responsible for any Copayment based on the Specialty Care Dentist's schedule of fees that have been approved by Horizon Healthcare Dental, Inc. The Copayment will vary based on the plan selected by the Policyholder.

D. SERVICES NOT COVERED

1. Benefits will be discontinued if the person ceases to be covered for any reason under the Policy or this rider.
2. Any services for an Orthodontic Procedure if an active appliance for that Orthodontic Procedure has been installed before the first day on which the person becomes covered by this rider.
3. Covered Services will not be provided for more than one complete course of orthodontic treatment in a person's lifetime.

All other benefits and terms of the Policy not changed above remain in force. This change is part of the Policy.