YOUR GROUP
DENTAL BENEFITS
UNITED OF OMAHA LIFE INSURANCE COMPANY
A Mutual *of* Omaha Company

FOR EMPLOYEES OF:

Trinity Management Services

CLASS(ES):

All Eligible Employees

EFFECTIVE DATE:

January 1, 2025

PUBLICATION DATE:

December 17, 2024

Group Number: G000CFQD

A written list of In-Network Providers is available to you through:

www.MutualofOmaha.com/dental or by calling customer service at: 1-800-927-9197

IF YOU ARE NOT SATISFIED WITH YOUR CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS AFTER YOU RECEIVE IT, UNLESS A CLAIM HAS PREVIOUSLY BEEN RECEIVED BY US UNDER YOUR CERTIFICATE. WE WILL REFUND WITHIN 30 DAYS OF OUR RECEIPT OF THE RETURNED CERTIFICATE ANY PREMIUM THAT HAS BEEN PAID AND THE CERTIFICATE WILL THEN BE CONSIDERED TO HAVE NEVER BEEN ISSUED. YOU SHOULD BE AWARE THAT IF YOU ELECT TO RETURN THE CERTIFICATE FOR A REFUND OF PREMIUMS, LOSSES WHICH OTHERWISE WOULD HAVE BEEN COVERED UNDER YOUR CERTIFICATE WILL NOT BE COVERED.

NOTICE

If you have any questions about or concerns with this insurance, please first contact the Policyholder or your benefits administrator. If after doing so you still have a question or concern, you may contact us at:

United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

Call Toll-Free: 1-800-927-9197

www.MutualofOmaha.com/dental

When contacting us, please have your Policy number and Member ID available.

THIS POLICY IS NOT IN LIEU OF AND DOES NOT AFFECT ANY REQUIREMENT FOR COVERAGE BY WORKERS' COMPENSATION INSURANCE.

General Notice of Interpretation and Translation Services

No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or 1-877-999-2330. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-877-999-2330 . للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 Arabic.

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) սոմսի վրա նշված կամ 1-877-999-2330 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-877-999-2330 與我們聯絡。欲取得其他協助，請致電1-800-927-4357 與加州保險部聯絡。Chinese

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-877-999-2330 . Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または 1-877-999-2330 までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-877-999-2330 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화 1-877-999-2330 번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره، 1-877-999-2330 تماس بگیرید. برای دریافت کمک بیشتر، به (اداره بیمه کالیفرنیا) CA Dept. of Insurance به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀ ਦੁਭਾਸੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-877-999-2330 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-877-999-2330 Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o a 1-877-999-2330 Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-877-999-2330 Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-877-999-2330 Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.

TABLE OF CONTENTS

CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy Number GUDS-CFQD (Policy) has been issued to Trinity Management Services (the Policyholder).

Insurance is provided to you by the Policyholder subject to the terms and conditions of the Policy. This Certificate is made part of the Policy.

Please read this Certificate carefully. The benefits described in this Certificate are effective only if you and your Dependents are eligible for the insurance, become insured and remain insured as described in this Certificate and according to the terms and conditions of the Policy.

If the provisions of this Certificate and those of the Policy do not agree, the provisions of the Policy will apply. The Policy is part of a contract between United of Omaha Life Insurance Company and the Policyholder, and may be amended, changed or terminated without your consent or notice to you.

James T. Blackledge
Chief Executive Officer

Jay C. Vanbeat
Corporate Secretary

SCHEDULE

This Schedule describes some of the terms and conditions of the Policy including the deductibles, benefit maximums, exclusions and limitations. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of the Certificate.

A person is not necessarily entitled to insurance under the Policy because he or she received this Schedule. A person is only entitled to insurance if he or she is eligible in accordance with the terms of the Certificate.

Benefits and Deductibles under the Policy may vary depending on Covered Services received In-Network or Out-Network.

All Providers are independent contractors; they are not our employees or agents. We do not supervise, control or guarantee the outcome or results of any services or supplies furnished by any Provider. Your relationship with a Provider is that of provider and patient. The Provider is solely responsible for the services and supplies provided to you.

IMPORTANT: If you opt to receive dental services that are not Covered Services under this Policy, a Network Provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call customer service at 1-800-927-9197 or your Benefits Administrator. To fully understand your coverage, you may wish to carefully review this Certificate.

POLICY INFORMATION

Policyholder:	Trinity Management Services
Policy Effective Date:	January 1, 2025
Policy Anniversary:	January 1
Policy Number:	GUDS-CFQD
Policy Year:	January 1 through December 31 of the same year
Classes:	All Eligible Employees
Network:	Mutually Preferred

GENERAL PROVISIONS

Deductible

The following Deductibles must be satisfied by you and each of your Dependents each Policy Year before any benefits are payable. Charges for treatments, procedures or supplies that are not Covered Services, or charges for treatments, procedures or supplies received during any applicable waiting period, may not be used to satisfy the Deductible.

Individual:	**In-Network**	**Out-Network**
Type A Covered Services	None	None
Type B and C Covered Services	$50	$50
Orthodontia Covered Services	None	None

Family:	**In-Network**	**Out-Network**
Type A Covered Services	None	None
Type B and C Covered Services	$150	$150
Orthodontia Covered Services	None	None

Covered Expenses will satisfy the Deductible for both In-Network and Out-Network.

If an Insured Person has been covered by a Prior Plan, any Deductible satisfied by them under the Prior Plan during the current Policy Year will be applied toward the satisfaction of their Deductible under the Policy for the same Policy Year.

Percentage Payable

If you or your Dependents receive a Covered Service described in this Schedule after the completion of any applicable waiting periods and the satisfaction of the Deductible, we will pay benefits according to the percentage of the Maximum Allowance shown in this provision, not to exceed the amount of the charge.

Benefits will not exceed the Policy Year Maximum Benefit described in this Schedule. Our obligation to pay benefits for Covered Services is subject to all terms and conditions of the Policy, including the exclusions and limitations as shown in this Schedule.

	In-Network	**Out-Network**
Type A Covered Services	100%	100%
Type B Covered Services	80%	80%
Type C Covered Services	50%	50%
Orthodontia Covered Services	50%	50%

You are responsible for all charges not payable under the Policy. Out-Network Providers may bill you for the balance of any charge over the Maximum Allowance.

Policy Year Maximum Benefit

The Policy Year Maximum Benefit will apply each Policy Year. This maximum benefit is the total amount of benefits payable for Type A, B and C Covered Services received by you or your Dependents during a Policy Year. After we have paid benefits equal to the Policy Year Maximum Benefit, no additional benefits are payable for Covered Services received during the same Policy Year.

	In-Network	**Out-Network**
Policy Year Maximum Benefit	$2,000	$2,000

Covered Expenses will satisfy the Policy Year Maximum Benefit for both In-Network and Out-Network.

Orthodontia Lifetime Maximum Benefit

Coverage is available to both Children and Adults.

The Orthodontia Lifetime Maximum Benefit is the total amount of orthodontia benefits payable for Covered Services incurred by an Insured Person while insured under any Policy. The Orthodontia Lifetime Maximum Benefit will apply for each Insured Person once while insured under any Policy. The amount of benefits payable under the Policy for orthodontia services and/or supplies will be reduced by the amount of Covered Expenses for orthodontia services and/or supplies received while covered under any Prior Plan.

	In-Network	**Out-Network**
Orthodontia Lifetime Maximum Benefit	$1,500	$1,500

Covered Expenses will satisfy the Orthodontia Lifetime Maximum Benefit for both In-Network and Out-Network.

Work in Progress

Benefits will be provided for dentures, bridgework, and cast restorations for which the final impression is taken prior to the date an Insured Person's insurance ends if final placement of the denture, bridgework, or cast restoration occurs within 180 days after the Insured Person's insurance ends.

Continuity of Care

While insured under this Policy, if you or your Dependent begins a course of treatment for a Serious Chronic Condition with a Network Provider and the Provider later terminates his or her participation in the Network, benefits will continue to be considered for Covered Services using the Network contracted allowance until that course of treatment is complete.

The completion of Covered Services will be provided for a period of time necessary to complete the current course of treatment and to assist in your selection of another Network Provider. Completion of Covered Services under this provision will not exceed 12 months from the Provider's Network termination date or 12 months from the effective date of coverage for a newly covered Insured Person.

In addition to a Serious Chronic Condition, continuity of care is also covered for treatment for Acute Conditions and performance of a surgery or other procedure that has been recommended and documented for the duration of the condition, Continuity of care for a surgery or other procedure will continue for up to 180 days after the Policy's termination date, or for 180 days following the effective date of coverage for a newly covered insured.

General Anesthesia Benefit

We will pay benefits for general anesthesia or I.V. (intravenous) sedation if the anesthesia is performed in the dental office, it is medically necessary for the treatment being performed, or the individual is incapacitated, or if it is used for a child age 6 and under.

Predetermination of Benefits

A predetermination of your benefits is available upon request. This will provide you and your dentist with information regarding a future course of treatment, allowing you to discuss treatment options with your dentist, including less expensive alternative treatment plans, or terms of payment to the dentist. Your dentist can submit a predetermination request on your behalf by completing a standard dental claim form and submitting it to:

Mutual of Omaha Insurance Company
P.O. Box 211472
Eagan, MN 55121

COVERED SERVICES

Benefits are payable under the Policy for Covered Services described in this section, subject to all terms and conditions of the Policy.

Type A Covered Services	**Benefit**
Examination/Evaluations	2 services in a 12 month period.
Bitewing X-rays	4 x-rays in a 12 month period.
Periapical or Occlusal X-rays	The submission of multiple x-rays on the same date of service will be benefited up to the maximum allowed for a Full Mouth Series of x-rays.
Fluoride Treatment	1 service in a 12 month period for Dependent children up to age 14.
Cleaning (Prophylaxis)	2 services in a 12 month period.
Brush Biopsy / Cancer Screen	2 services in a 12 month period.

Type B Covered Services	**Benefit**
Full Mouth Series or Panoramic X-rays	1 service in a 60 month period.
Sealants	1 service per occlusal surface of first and second permanent molars without existing fillings in 36 month period for Dependent children up to age 14.
Space Maintainers, including recementation	Benefits are payable for initial placement and any recementation for Dependent children up to age 14.
Palliative Treatment	Benefits are payable for treatment of minor dental pain.
Periodontal Maintenance	2 services in a 12 month period in addition to routine cleanings. Benefits are payable only when this procedure follows active periodontal treatment.
Fillings	Benefits are payable for amalgam (silver) and composite/resin (white) fillings. Composite fillings on molars are limited to the amount otherwise payable for an amalgam filling. Replacement of fillings allowed once in a 24 month period.

Type C Covered Services	**Benefit**
Stainless Steel and Other Prefabricated Crowns	Benefits are payable 1 per tooth per lifetime up to age 16.
Simple Extractions	Benefits are payable for simple extractions of erupted teeth.
Surgical Extractions	Benefits are payable for the extraction of teeth requiring a cutting procedure.
Endodontics	Benefits are payable for services such as pulpal therapy and root canal therapy. Retreatment of a root canal is payable once in a lifetime and only after 12 months have passed since the original root canal was completed.
Periodontics – Surgical	Benefits are payable for surgical treatment of gum and supporting bone disease. Services are limited to one service per area of the mouth in a 24 month period.
Periodontics – Non-Surgical	Benefits are payable for non-surgical services such as scaling and root planning. Services are limited to one service per area of the mouth in a 24 month period.
Full or Partial Removable Dentures	Benefits are payable for final dentures.
Replacement of Full or Partial Removable Dentures	Benefits are payable if the existing denture is more than 10 years old or significant structural changes occurred within the mouth due to extractions or other oral surgery.
Repair of Full or Partial Removable Dentures	Benefits are payable if the service is performed more than 6 months after initial denture placement. Benefits are payable once in any 36 month period. Benefits include the addition of teeth to a denture.
Adjustments to Full or Partial Removable Dentures	Benefits are payable if the service is performed more than 6 months since initial insertion of the denture. Payable once in 12 months thereafter.
Tissue Conditioning, Rebasing or Relining of Full or Partial Removable Dentures	Benefits are payable if the service is performed more than 6 months after any previous adjustment, tissue conditioning, rebasing or relining. Payable once in 36 months thereafter.

Bridgework	Benefits are payable for the replacement of lost, extracted, or congenitally missing teeth. Benefits are payable for Insured Persons age 16 and older.
Replacement of Bridgework	Benefits are payable if the existing bridgework is more than 10 years old or significant structural changes occurred within the mouth due to extractions or other oral surgery.
Repair and Recementation of Bridgework	Benefits are payable if the service is performed more than 6 months after initial bridge placement. Payable once in 12 months thereafter.
Cast Crowns, Inlays, Onlays, and Labial Veneers	Benefits for veneered molar crowns are equal to the amount otherwise payable for cast metal crowns. Benefits are payable for damage due to decay or tooth fracture, but only if the tooth cannot be restored with standard filling material. Benefits are payable for Insured Persons age 16 and older.
Replacement of Cast Crowns, Inlays, Onlays, and Labial Veneers	Benefits are payable if the existing crown, inlay, onlay or veneer is more than 10 years old and cannot be repaired.
Repair and Recementation of Cast Crowns, Inlays, Onlays, and Labial Veneers	Benefits are payable if the service is performed more than 6 months after initial restoration placement. Payable once in 12 months thereafter.
Implants	Once per tooth per lifetime.
Oral surgery	Benefits are payable for oral surgery, including x-rays, pre- and post-operative care, and surgical extractions. This benefit does not include TMD surgery.
General Anesthesia or Intravenous (I.V.) Sedation	Benefits are payable when service is provided with a covered surgical procedure.

Orthodontic Covered Services	**Benefit**
Dependent Child and Adult	Benefits are payable for orthodontic services including x-rays, case work up, consultation, appliances, and post-treatment retention. Orthodontic treatment is deemed to have begun at the time of banding and/or when other orthodontic appliances are initially placed in connection with a current course of treatment.
Harmful Habit Appliance	Benefits are payable for Dependent children up to age 14. Includes all adjustments.

EXCLUSIONS

We will not pay benefits for any treatment, procedure or supply:

a) not identified as a Covered Service in this Schedule;
b) considered an Experimental or Investigational Device, Treatment or Procedure;
c) not considered Medically Necessary, provided for patient convenience, or provided solely to relieve mental anxiety, unless specifically provided in the Schedule;
d) when benefits are payable under any other group health or dental plan maintained or sponsored by the Policyholder;
e) related to tests and laboratory exams, bacteriologic studies, caries susceptibility tests, pulp vitality tests, oral pathology laboratory, oral hygiene instruction, education or training, histopathologic examinations, diagnostic casts and photographs, the diagnosis or treatment of congenital malformations, magnetic resonance imaging and gnathological procedures, services, supplies or procedures related to orthognathic surgery, osteoplasties, osteotomies, LeFort procedures, maxillofacial prosthetics, vestibuloplasties, stomatoplasties, and any procedures related to the diagnosis or treatment of jaw fractures;
f) related to the diagnosis or treatment of Temporomandibular Disorders (TMD) and functional/myofunctional therapy except to the extent as may be required by state law, or unless specifically provided in the Schedule;
g) related to Cosmetic or Reconstructive Procedures;
h) related to restorations, devices, appliances or dentures to change vertical dimension, to alter occlusion or to replace tooth structure lost through attrition, erosion or abrasion including occlusal adjustment or equilibration;
i) related to the replacement of lost dentures or the replacement of lost or broken appliances;
j) related to athletic mouth guards, bruxism appliances or any procedure related to such appliance, except as specifically provided in the Schedule as an orthodontic procedure;
k) related to precision attachments, connector bars, coping materials, overdentures, unilateral partial dentures and stress breakers;

l) related to drugs and medications whether or not they require a written prescription, or for analgesics or euphoric drugs, except as specifically provided in the Schedule;
m) related to cast restorations, full or partial dentures and fixed bridgework when the final impressions were taken before the date insurance began or after insurance ends;
n) customarily performed in association with a more comprehensive dental procedure, including local anesthesia, pulp capping (direct or indirect), insulating/cementing bases, periodontal splinting (permanent or provisional), temporary crowns, bridges, and dentures; or any minor associated gingival involvement when performed in conjunction with a cast restoration or fixed bridgework;
o) related to any endodontic, periodontic, crown, bridge abutment or appliance performed on teeth with a guarded, questionable or poor prognosis;
p) related to duplication of treatments, procedures or supplies, including when an Insured Person transfers from the care of one Provider to the care of another Provider;
q) that arise out of or in the course of employment for any employer or that Insured Person is paid benefits under any workers' compensation or occupational disease law, or receives any settlement from a worker's compensation carrier;
r) when the Insured Person is not liable for payment;
s) provided or paid for by a state or federal government or its agencies;
t) resulting from an intentionally self-inflicted injury;
u) resulting from the Insured Person's voluntary participation in a riot or in the commission of a felony;
v) resulting from an act of declared or undeclared war or armed aggression;
w) incurred while the Insured Person is on active duty or training in the Armed Forces, National Guard, Reserves or an auxiliary unit of any state or country or which any governmental body or its agencies are liable;
x) provided by a person who is a member of your family (your Spouse or Registered Domestic Partner; or a child, brother, sister or parent of you or your Spouse or Registered Domestic Partner).

ELIGIBILITY

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

WHEN YOU BECOME ELIGIBLE FOR INSURANCE (ELIGIBILITY WAITING PERIOD)

If you are Actively Working on the Policy Effective Date, you become eligible for insurance on the Policy Effective Date.

If you are not Actively Working on the Policy Effective Date or if you are hired after the Policy Effective Date, you become eligible for insurance on the day you begin Active Work.

The day you become eligible for insurance may not be the same as the day insurance begins. The WHEN INSURANCE BEGINS FOR YOU provision describes the day insurance begins.

WHEN A DEPENDENT BECOMES ELIGIBLE FOR INSURANCE

Provided you elect insurance for yourself, your Dependents become eligible for insurance on the later of:

a) the day you become eligible for insurance; or
b) the day you acquire the Dependent.

If both you and your Spouse are eligible for and elect insurance as Employees:

a) neither you nor your Spouse or Registered Domestic Partner may elect insurance as a Dependent of the other person; and
b) both you and your Spouse or Registered Domestic Partner may elect insurance for your Dependent children.

The day a Dependent becomes eligible for insurance may not be the same day insurance begins**.** The WHEN INSURANCE BEGINS FOR YOUR DEPENDENT provision describes the day insurance begins.

WHEN INSURANCE BEGINS FOR YOU

You must enroll for any insurance requiring an election by submitting a Written Request for insurance. The Written Request must be submitted to the Policyholder no later than 31 days after the day you become eligible. If the Written Request for insurance is not submitted within the required timeframe, you may not enroll until a Subsequent Enrollment Period is offered.

You become insured on the first day of the month which follows the latest of the day:

a) you become eligible and are Actively Working; or
b) your Written Request is properly completed and signed, if required.

WHEN INSURANCE BEGINS FOR YOUR DEPENDENT

You must enroll your eligible Dependents for insurance requiring an election by submitting a Written Request for insurance. The Written Request must be submitted to the Policyholder no later than 31 days after the day your Dependents become eligible. If the Written Request for insurance is not submitted within the required time frame, you may not enroll your eligible Dependents until a Subsequent Enrollment Period is offered.

An eligible Dependent will become insured on the latest of the day:

a) you become insured;
b) you acquire the eligible Dependent; or
c) your Written Request to enroll the Dependent is properly completed and signed, if required.

Insurance for a Dependent child who became Incapacitated prior to reaching the age of 26 begins in accordance with the above terms, provided the child otherwise meets the definition of Dependent.

Insurance for a newborn child begins at the moment of live birth. Insurance for a newly adopted child begins with the date of placement into your custody or at the moment of live birth, if a written agreement to adopt the child was previously entered into by you. If Dependent child insurance for any other child is not already in effect, a Written Request for insurance for any newborn or newly adopted Dependent child must be submitted to the Policyholder within 31 days after the day the Dependent child becomes eligible in order to continue insurance beyond the 31-day period. If Dependent child insurance is already in effect, you may add the new child at any time prior to their third birthday. If the child is not added prior to turning age 3, you may not enroll the child until a Subsequent Enrollment Period is offered.

FIRST ENROLLMENT PERIOD

You may elect insurance for you and any eligible Dependents during your First Enrollment Period.

If you do not elect insurance during your First Enrollment Period, any future election may only be made in accordance with the SUBSEQUENT ENROLLMENT PERIOD provision, or as otherwise provided under the WHEN ELECTION CHANGES ARE PERMITTED provision.

SUBSEQUENT ENROLLMENT PERIOD

You may elect, drop, or change insurance for you or your Dependents during a Subsequent Enrollment Period.

WHEN ELECTION CHANGES ARE PERMITTED

Life Events

The Policyholder has chosen to provide these insurance benefits under a Section 125 cafeteria plan. A cafeteria plan permits you to elect to pay your share of the cost of insurance with pre-tax dollars and permits you to change your elections only when specific life events occur, other than during a Subsequent Enrollment Period. You may make an election change by submitting a Written Request to the Policyholder within 31 days after the date of a life event.

Life events are described in the Policyholder's cafeteria plan. Contact the Policyholder for information regarding the election changes that are permissible under the Policyholder's cafeteria plan.

REINSTATEMENT OF INSURANCE

You may be eligible to reinstate insurance that has ended in accordance with this provision. For any insurance requiring an election, you must submit a Written Request to reinstate insurance within 45 days of your return to Active Work. A standard enrollment form may be used for this request. If the Written Request is submitted more than 45 days after the date you return to Active Work, you may not re-enroll for insurance until a Subsequent Enrollment Period is offered. If insurance is reinstated for you, insurance may also be reinstated for any eligible Dependents.

Reinstated insurance will take effect on the first day of the month that follows the date of the Written Request. If you are not Actively Working on the day the reinstated insurance would otherwise take effect, insurance will become effective on the day after you return to Active Work.

Non-Payment of Premium or Voluntary Termination of Insurance

If insurance ends because you do not pay premium or you voluntarily terminate insurance, you may not re-enroll for insurance until a Subsequent Enrollment Period is offered.

Involuntary Reduction in Hours

If insurance ends because you are no longer Actively Working due to an involuntary reduction of hours worked, insurance may be reinstated without satisfying another Eligibility Waiting Period if you return to Active Work and there is no break in employment with the Policyholder after the date insurance ended.

Rehired Due to Layoff or Termination

If insurance ends because you are no longer Actively Working due to layoff or termination of employment with the Policyholder, insurance may be reinstated without satisfying another Eligibility Waiting Period if you are rehired and return to Active Work within 90 days from the date insurance ended.

Rehired Due to Leave of Absence

If insurance ends because you are no longer Actively Working due to an approved leave of absence, including military leave, insurance may be reinstated within 90 days from the date insurance ended without satisfying another Eligibility Waiting Period upon your return to Active Work. If insurance ends because you are no longer Actively Working due to military leave, insurance may be reinstated upon return to Active Work within 31 days of discharge from active duty without satisfying another Eligibility Waiting Period.

WHEN INSURANCE ENDS

Unless otherwise stated or allowed in the Policy, insurance ends on the earliest of:

a) the last day of the month you or your Dependent are no longer eligible for insurance;
b) the last day of the month you or your Dependent begin active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 31 days or less);
c) the day the Policy terminates; or
d) in accordance with the GRACE PERIOD provision.

If insurance ends, it may be reinstated as described in the REINSTATEMENT OF INSURANCE provision in the Eligibility section of this Certificate.

GRACE PERIOD

There is a grace period of 60 days for payment of premium. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 60-day grace period that follows. We consider premium to be paid on the date we receive it.

Insurance will stay in force during the grace period as long as premium is paid before the end of the grace period. If we receive written notice requesting cancellation of insurance on a current or future date, the grace period will not apply. Coverage will end on the cancellation date specified in such notice, as long as the full premium has been paid up to that date.

If premium is not paid by the end of the grace period, insurance will end the day after the last day of the grace period.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for you and/or your Dependents would otherwise end, you or your Dependents may be eligible to continue insurance under one of the following provisions:

a) CONTINUATION OF INSURANCE FOR LAYOFF, LEAVE OF ABSENCE OR PAID SEVERANCE
b) COBRA CONTINUATION

CONTINUATION OF INSURANCE FOR LAYOFF, LEAVE OF ABSENCE OR PAID SEVERANCE

If there is a conflict between this provision and any other provision of the Policy, this provision controls.

You may be able to continue insurance for you and your Dependents from the day you cease to be Actively Working in the event of:

a) a temporary involuntary layoff;
b) a personal leave of absence approved by the Policyholder due to:
    1. an injury or sickness; or
    2. any other personal reason.

In addition, the federal Family Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as certain state laws, allow continuation of insurance in certain instances. Contact the Policyholder for additional information regarding any other continuation options that may be available.

You may also be able to continue insurance from the day you cease to be Actively Working if you are entitled to and receive paid severance from the Policyholder. Contact the Policyholder to determine if this continuation option is available.

Any insurance continued under this provision is subject to the following conditions.

a) Insurance may not be continued beyond the earliest of:
    1. end of month;
    2. the time period allowed by FMLA, USERRA or applicable state law that allows for continuation; or
    3. the time period during which you receive paid severance.
b) The amount of insurance for any Insured Person may not be increased while insurance is continued under this provision.
c) We receive verification of the approved layoff, leave, reduced hours, or severance from the Policyholder.
d) We continue to receive premium payment when due (premiums must be paid by you or on your behalf).

Insurance under this provision ends on the earliest of the day:

a) the time period in a) in the preceding paragraph has been satisfied;
b) your temporary involuntary layoff becomes permanent;
c) you return to Active Work;
d) you begin full-time employment with an employer other than the Policyholder; or
e) the Policy terminates.

See the OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE provision for premium payment options.

COBRA CONTINUATION

The COBRA CONTINUATION provision applies only if the Policyholder employed 20 or more employees on at least 50 percent of its business days during the preceding calendar year.

For You and Your Dependents

You and/or any insured Dependent who is a Qualified Beneficiary may elect to continue insurance under the Policy for as long as 18 months from the day your coverage ends because of these qualifying events:

a) your employment terminates (other than due to gross misconduct); or
b) you no longer satisfy the requirements for hours worked.

If an Insured Person is determined, in accordance with Title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continued coverage, the reference to 18 months in the preceding sentence is deemed a reference to 29 months. Notice of such determination must be given to the Plan Administrator before the first 18 months of continued coverage ends and within 60 days of the date of the determination. Refer to the Payment of Premium section below.

During the period you continue coverage:

a) any new eligible Dependents you acquire may be added in accordance with the WHEN A DEPENDENT BECOMES ELIGIBLE FOR INSURANCE provision; and
b) any eligible Dependents you declined to insure before your continued insurance under the Policy began may be added during any open enrollment period provided by the Policy provided any additional premium is paid. However, such Dependents, other than a Qualified Beneficiary, who are added after the qualifying event will not be entitled to continue coverage as Qualified Beneficiaries after an event occurs as shown in the For Your Dependents Only section below.

For Your Dependents Only

Your insured Spouse who is a Qualified Beneficiary and/or each of your insured Dependent children who is a Qualified Beneficiary may elect to continue insurance under the Policy for as long as 36 months from the day coverage ends because of these qualifying events:

a) you die;
b) you become entitled to Medicare benefits;

c) you and your Spouse are legally separated;
d) your marriage is ended by divorce; or
e) a child is no longer an eligible Dependent.

If your Dependent is already continuing coverage under the *For You and Your Dependents* section above when an event shown in the *For Your Dependents Only* section occurs, that second event will not entitle your Dependent to continue coverage beyond 36 months under the *For You and Your Dependents* and *For Your Dependents Only* sections combined.

If your Dependent becomes entitled to continue insurance under both the *For You and Your Dependents* and *For Your Dependents Only* sections on the same day, the periods of continued coverage will run concurrently and will not exceed 36 months.

Notice Requirements

Your employer is required by law to notify the Plan Administrator within 30 days after your termination of employment, reduction in hours, death or entitlement to Medicare. You must notify the Plan Administrator within 60 days after the day you are legally separated or divorced, or your child ceases to be an eligible Dependent.

If an Insured Person is determined, in accordance with Title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continued coverage, that person must:

a) notify the Plan Administrator within 60 days of the date of the determination and before the first 18 months of continued coverage ends; and
b) notify the Plan Administrator within 30 days of the date of any final determination that he or she is no longer disabled. Then, continued coverage ends the first day of the month that begins more than 30 days after the date of such final determination.

Within 14 days after receiving notice of a qualifying event, the Plan Administrator will send you or your Dependent written notice of the continuation right. The Plan Administrator must receive your or your Dependent's written request to continue insurance under the Policy within 60 days after the day:

a) insurance ends; or
b) the Insured Person is sent notice of the continuation right; whichever is later.

Payment of Premium

To continue coverage, you or your Dependent must pay the required premium, including any retroactive premium. The initial premium must be paid to the Plan Administrator within 45 days after the day continued coverage is elected. The Plan Administrator will inform you or your Dependent of procedures to pay subsequent monthly premiums.

End of Continuation

An Insured Person's continued insurance will end at midnight on the earliest of:

a) the day your employer ceases to provide any group dental plan to any employee;
b) the day premium is due and unpaid;
c) the day the Insured Person is covered under any other group dental plan as an employee or otherwise; however, this does not apply when the Insured Person is covered under a similar group plan which contains any preexisting condition limitations which apply to that person. Then, he or she may continue coverage under the Policy until the earlier of:
    1. the day the preexisting conditions limitation under the new group plan no longer applies; or
    2. the day continued coverage would otherwise end;
d) 18 months (or 29 months or 36 months as provided above) from the day your coverage ends under the Policy;
e) the day an Insured Person again becomes covered under the Policy;
f) the day an Insured Person is entitled to benefits under Medicare;
g) the day the Policy terminates.

Other Continuation Provisions

In the event insurance is continued under any other continuation provisions of the Policy, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which premium is paid in whole or in part by your employer, then the premium you are required to pay may increase for the remainder of the 18-month, 29-month, or 36-month period provided above.

CAL-COBRA

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

The employer must notify the insurer, United of Omaha Life Insurance Company, within 30 days of a qualifying event for an eligible employee and/or covered dependents.

Qualifying Events for Covered Employees and Dependents

- Employee's voluntary or involuntary termination of employment (except for gross misconduct)
- Employee's reduction in hours

Requirements for Covered Employees and Dependents

The insurer must send an election form to the qualified beneficiary within 14 days of receiving such notice from the employer.

The qualified beneficiaries must notify the insurer of their election to continue coverage within 60 days of the qualifying event. Failure to do so will disqualify the beneficiary from receiving continuation coverage under the Cal-COBRA provisions. A beneficiary who wishes to continue coverage under the group benefit plan following the Cal-COBRA provisions must request the continuation in writing.

The notice must be delivered to the insurer by first class mail, personal delivery, express mail or private courier company (collectively referred to as "Reliable Means of Delivery"). This notice must be delivered within the 60-day period following the date the insured's coverage under the group benefit plan ended or will end because of one of the above events, or the date the insured was sent notice of ability to continue coverage under the group benefit plan.

Qualifying Events for Covered Dependents

- Death of the covered employee
- Divorce, termination of domestic partnership or legal separation of the covered employee from his/her spouse or Registered Domestic Partner
- Loss of dependent status by a dependent enrolled in the group benefit plan
- The covered employee's entitlement to benefits under Title XVIII of the United State Social Security Act (Medicare).

Requirements for Covered Dependents

The covered dependent must notify the insurer within 60 days of any of the above qualifying events. Failure to do so will disqualify the beneficiary from receiving continuation coverage under the Cal-COBRA provisions. A beneficiary who wishes to continue coverage under the group benefit plan following the Cal-COBRA provisions must send the notice requesting continuation in writing.

Additional Requirements for Employees and Covered Dependents

For coverage to continue under Cal-COBRA, the beneficiary must pay the required initial premium to the insurer within 45 days of the date the beneficiary provided written notice to the insurer of the election to continue coverage. The initial premium shall be delivered to United of Omaha Life Insurance Company by a reliable means of delivery. Failure to submit the premium within the 45 days shall disqualify the beneficiary from receiving continuation coverage under Cal-COBRA.

After the initial payment, the regular monthly premium must be received timely or Cal-COBRA coverage will terminate. Subsequent monthly premiums are due the first day of each monthly period of Cal-COBRA coverage.

If the Group Policy ends during the continuation period and the health coverage is replaced by another group plan, the insured's coverage will continue under the replacing policy until the Cal-COBRA coverage period has ended (provided the beneficiary has no lapse in coverage prior to coverage being replaced).

If the beneficiary fails to comply with the enrollment and premium payment requirements of the new group benefit plan within 30 days of receiving notice that the prior group health plan ended, coverage under the replacing policy will end.

If the Group Policy ends during the continuation period and the group coverage is not replaced by another group plan, Cal-COBRA coverage will cease on the date the Group Policy ends.

For more information
If you have questions, please contact United of Omaha Life Insurance Company at 800-655-5142.

OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE

When insurance is continued, we must receive premium payment when due (premiums must be paid by you or on your behalf) for insurance to remain effective. This can occur in one of the following ways:

a) the Policyholder may pay the premiums; or
b) you may pay premium to the Policyholder who will then submit premium to us.

Contact the Policyholder to determine which option is available to you.

Payment of premium does not guarantee eligibility for coverage.

CLAIM PROVISIONS

CLAIM FORMS

Before benefits can be considered, we must be given written notice of claim (a claim form) as described in this section.

You do not need to submit a claim form to us if services are received In-Network. If services are received Out-Network, you must submit a claim form to us.

You may use a standard claim form supplied by your Provider or you may find a form on our website: **www.MutualofOmaha.com/dental**, or call customer service at 1-800-927-9197. A claim form requested from customer service will be provided to you within 15 days.

If the form is not furnished to you before the expiration of 15 days after we receive your request, you will be considered to have complied with the requirements of the Policy as to written Notice of Claim by submitting to us a statement covering the occurrence, character, and extent of the loss for which claim is made.

NOTICE OF CLAIM

Written notice of claim (a claim form) must be given to us within 12 months from the date of service. If it is not reasonably possible to give us notice of claim within the required time, we will not deny a claim filed for this reason if the claim is supplied as soon as reasonably possible, unless you are legally incapable.

We may require supporting information which may include, but is not limited to, clinical records, charts, x-rays, and other diagnostic aids.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form to:
Mutual of Omaha Insurance Company
P.O. Box 211472
Eagan, MN 55121

CLAIM ASSISTANCE

For assistance with filing a claim or an explanation of how a claim was paid, contact:
Mutual of Omaha Insurance Company
P.O. Box 211472
Eagan, MN 55121
Call Toll-Free: 1-800-927-9197

PAYMENT OF CLAIMS

Benefits will be paid immediately after we receive acceptable written notice of claim and any other required supporting information.

Benefits will be paid to the Provider if services are received In-Network. If services are received Out-Network, benefits will be paid to you, unless you or your Dependent have assigned benefits to the Provider.

Unless you have assigned this insurance, benefits for any Insured Person will be paid to you. Benefits unpaid at your death will be paid to:

a) any relative who is entitled to the benefits; or
b) your estate.

With each claim payment, we will provide you an explanation of benefits that includes the name of the provider, services submitted, amount charged, dates of service and a reasonable explanation of the computation of benefits.

CLAIM REVIEW AND APPEAL PROCESS

Appeals, Complaints, Grievances should be mailed to:
Mutual of Omaha: Appeals & Grievances
P.O. Box 211472
Eagan, MN 55121

Claim Review

We will notify you in writing of our decision to either approve or deny a claim within 40 days of the date it is received by us. If we deny your claim in whole or in part, we will explain the reasons for our denial in our notice. If you disagree with the reasons given, you or your authorized representative may ask that we reconsider your claim through the appeal process.

Appeal Process

To appeal a denied claim, you or your authorized representative must notify us within 180 days after receiving notice of our denial and ask that we reconsider our original benefit decision. Your appeal request must be submitted to us in writing or electronically and should state the reasons why you believe the claim denial was incorrect. You should also include any additional information, documents or other materials that might allow us to change our original decision. Send your appeal request to us at the address shown in the CLAIM ASSISTANCE provision.

The request for an appeal should include:

a) the Policyholder's name and the Policy number;
b) the patient's name and date of birth;
c) the date of service to be reviewed;
d) the Employee name, Member ID, and mailing address;
e) the name and address of the treating Dentist; and
f) the reason for the appeal.

By requesting an appeal, you have authorized us, or anyone designated by us, to review any and all records (including medical/dental records) which may be relevant to your appeal.

Within 60 days after receiving your appeal request, we will notify you or your authorized representative in writing of our final claim decision. If we need more time due to circumstances beyond our control, we will inform you of our need for an extension prior to the end of this time frame.

Notice

If the administration of the Policy is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of your claim or to ask questions about your rights under ERISA.

REFUND TO US

If it is found that we paid more benefits than we should have paid under the Policy, we will have the right to a refund from you or the recipient of benefits.

We also have a right to a refund for any payments due to:

a) fraud or misrepresentation;
b) any error we make in processing a claim;
c) you or your agent's failure to provide complete information; or
d) you or your Dependent not being eligible for coverage.

You or the recipient of benefits must reimburse us in full. We will determine the method the repayment is to be made, including without limitation, reducing or withholding any benefits payable under this or any other group insurance policy issued by us. We will credit any such payments to the refund until the refund is fully recovered.

If it is found that we paid less benefit than we should have paid under the Policy, we will make additional payments, as necessary.

INDEPENDENT EXAMINATION

We may require an Insured Person to be examined by a Dentist as we direct to assist in determining whether benefits are payable.

We will pay for these examinations. We will not require more than a reasonable number of such examinations.

STANDARD PROVISIONS

ENTIRE INSURANCE CONTRACT

The insurance contract consists of:

a) the Policy, including this Certificate; and
b) the Policyholder's application attached to the Policy.

Any statement made by the Policyholder or you will, in the absence of fraud, be considered a representation and not a warranty.

CHANGES IN THE INSURANCE CONTRACT

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time we and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

a) does not require the consent of any Insured Person or beneficiary; and
b) must be:
    1. in writing;
    2. made a part of the Policy; and
    3. signed by one of our home office executive officers.

A change may affect any class of Insured Persons included in the Policy.

DELEGATION

We may delegate some of our obligations and responsibilities under the Policy, such as claims administration, network management and other administrative services, to a third party designated by us. Any delegation of obligations and responsibilities will be done in compliance with applicable California law and in no way relieves us from responsibility for the actions taken and decisions made by such third party.

LEGAL ACTIONS

No action at law or in equity will be brought to recover on this Policy prior to the expiration of 60 days after written notice of claim has been furnished in accordance with the requirements of this Policy. No such action will be brought after the expiration of 3 years after the time notice of claim is required to be furnished, unless otherwise required by state law in your state of residence.

CONFORMITY WITH STATE AND FEDERAL LAW

Any provision of the Policy which, on its effective date, is in conflict with the law of the federal government or the state in which an Insured Person resides on such date is hereby amended to conform to the minimum requirements of such law.

COORDINATION OF BENEFITS (COB)

a) This provision will apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Covered Expenses incurred as to such person during such period, the sum of:
    1. the benefits that would be payable under this Plan in the absence of this provision, and
    2. the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such Covered Expenses.

b) As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision for the Covered Expenses incurred as to such person during such Claim Determination Period will be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Covered Expenses under all other Plans, except as provided in paragraph c) below, will not exceed the total of such Covered Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor.

c) If:
    1. another Plan which is involved in paragraph b) above and which contains a provision coordinating its benefits with those this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and
    2. the rules set forth in paragraph d) below would require this Plan to determine its benefits before such other Plan, then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.

d) For the purposes of paragraph c) above, the rules establishing the order of benefit determination are:
    1. The benefits of a Plan which covers the person on whose expenses claim is based other than as a Dependent will be determined before the benefits of a Plan which covers such person as a Dependent.
    2. Except for cases of a person for whom claim is made as a Dependent child whose parents are separated, divorced, or have terminated their domestic partnership, the benefits of a plan which covers the person on whose expenses claim is based as a Dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, will be determined before the benefits of a Plan which covers such person as a Dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either Plan does not have the provisions of this paragraph regarding Dependents, which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions of this paragraph will not apply, and the rule set forth in the Plan which does not have the provisions of this paragraph will determine the order of benefits.
    3. In the case of a person for whom claim is made as a Dependent child whose parents are separated, divorced, or have terminated their domestic partnership, and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a Dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a Dependent of the parent without custody.
    4. In the case of a person for whom claim is made as a Dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a Dependent of the parent with custody will be determined before the benefits of a Plan which covers that child as a Dependent of the stepparent, and the benefits of a Plan which covers that child as a Dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a Dependent of the parent without custody.
    5. In the case of a person for whom claim is made as a Dependent child whose parents are separated, divorced, or have terminated their domestic partnership, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding paragraphs 3. and 4. above, the benefits of a Plan which covers the child as a Dependent of the parent with such financial responsibility will be determined before the benefits of any other Plan which covers the child as a Dependent child.
    6. When rules 1. through 5. do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time will be determined before the benefits of a Plan which has covered such person the shorter period of time, provided that:
        a. the benefits of a plan covering the person on whose expenses claim is based as a laid-off or retired employee, or Dependent of such person, will be determined after the benefits of any other Plan covering such person as an employee, other than a laid-off or retired employee, or Dependent of such person; and

b. if either Plan does not have a provision regarding laid-off or retired employees, which results in each Plan determining its benefits after the other, then the provisions of a. above will not apply.

e) When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Period, each benefit that would be payable in the absence of this provision will be reduced proportionately, and such reduced amount will be charged against any applicable benefit limit of this Plan.

Instructions

a) When a claim under a Plan with a COB provision involves another Plan which also has a COB provision, the carriers involved will use the above rules to decide the order in the, which the benefits payable under the respective plans will be determined.

b) In determining the length of time an individual has been covered under a given Plan, two successive Plans of a given group will be deemed to be one continuous Plan so long as the claimant concerned was eligible for coverage within 24 hours after the prior Plan terminated. Thus, neither a change in the amount or scope of benefits provided by a Plan, a change in the carrier insuring the Plan, nor a change from one type of Plan to another, (e.g. single employer to multiple employer Plan, or vice versa, or single employer to a Taft-Hartley Welfare Plan) would constitute the start of a new Plan for purposes of this instruction.

c) If a claimant's effective date of coverage under a given Plan is subsequent to the date the carrier first contracted to provide the Plan for the group concerned (employer, union, association, etc.), then, in the absence of specific information to the contrary, the carrier will assume, for purposes of this instruction, that the claimant's length of time covered under that Plan will be measured from claimant's effective date of coverage. If a claimant's effective date of coverage under a given Plan is the same as the date the carrier first contracted to provide the Plan for the group concerned, then the carrier will request the group concerned to furnish the date the claimant first became covered under the earliest of any prior Plans the group may have had. If such date is not readily available, the date the claimant first became a member of the group will be used as the date from which to determine the length of time his coverage under that Plan has been in force.

d) It is recognized that there may be existing group plans containing provisions under which the coverage is declared to be “excess” to all other coverages, or other over insurance provisions not consistent with the provisions of these regulations. Such plans may have been written by certain self-insured or non-regulated entities not presently subject to insurance regulation, or by insurers or service corporations under policies or contracts issued prior to the effective date of these regulations, and which have not yet been brought into conformance with these regulations. In such cases, carriers are urged to use the following claims administration procedures: A group contract should pay first if it would be primary under the COB order of benefit determination. In those cases in which it would normally be considered secondary, the carrier should make every effort to coordinate in the secondary position with benefits available through such “excess” plans. The carrier should try to secure the necessary information from the “excess” plan.

e) Provision (c) may be omitted if the plan provides only one benefit.

f) A group contract which includes COB and which is issued or renewed, or which has an anniversary date on or after the effective date of this section as amended in 1986 will include the substance of the provision in subsection c) 2. of this section. That provision will become effective, at the option of the insurer, on January 1, 1987, or one year after the effective date of this section as amended in 1986. Until that provision becomes effective, the group contract will, instead, use wording like this:

“(2) except as stated in paragraphs (3), (4) and (5), below, the benefits of a plan which covers a person as a dependent of a male are determined before those of a plan which covers the person as a dependent of a female.”

REQUEST TO COLLECT AND RELEASE NEEDED INFORMATION

In order to receive benefits, the Claimant may be asked to provide additional information needed to coordinate benefits. With the Claimant’s consent, we may release to or collect from any person or organization any applicable coordination of benefits related information about the Claimant.

PLAN REIMBURSEMENT FOR THIRD PARTY PAYMENT

If benefits, which this Policy should have paid, are instead paid by another Plan, we will reimburse you. Amounts reimbursed will be considered to be benefits paid under the Policy and will be treated in the same manner as other benefits under the Policy in accordance with the terms of the Policy.

RIGHT OF RECOVERY

If the Policy pays more for a Covered Expense than is required by this COB provision, the excess payment may be recovered from the Claimant or any person whom the payment was made.

DEFINITIONS

The defined terms used in this Certificate and Policy are shown in this section. With the exception of *our, we, us, you, your* and *yourself*, we have capitalized these terms wherever they appear to make them easier for you to find.

The definitions set forth below apply to both the singular and plural versions of the defined term.

Actively Working, *Active Work* means you are:

a) performing the normal duties of your regular occupation for the Policyholder on a regular and continuous basis 30 or more hours each week; and
b) receiving compensation from the Policyholder for work performed for the Policyholder.

You will be considered to be actively working on any day that is a regular paid holiday or day of vacation, or regular or scheduled non-working day, provided you were actively working on the last preceding regular work day.

Acute Condition means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

Calendar Year means the 12-month period beginning on January 1 of each year and ending on December 31 of the same year.

Certificate means this document that describes the benefits, terms, conditions, exclusions and limitations of the insurance provided under the Policy.

Charge, Charged, Charges means the amount billed by a Provider for services provided to you or your Dependent.

Claim Period means part or all of a Policy Year during which the Insured Person is insured under the Policy.

Claimant means the person who submits a claim for benefits for any Insured Person, including the authorized representative of such person.

Cosmetic or Reconstructive Procedure means any treatment or procedure performed or supply provided primarily to:

a) improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction, condition or disease; or
b) prevent or treat a mental or nervous disorder through a change in bodily form.

Covered Expense means any charge which meets all of the following requirements:

a) it is a charge for an item of Medically Necessary Expense;
b) it is an expense which the Claimant must pay; and
c) it is an expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan during a Claim Period.

However, any expense which is not payable by the Primary Plan because of the Claimant's failure to comply with cost containment requirements will not be considered a Covered Expense by this Plan if this Plan is the Secondary Plan.

Covered Service means a dental treatment, procedure or supply that is:

a) Medically Necessary;
b) described in the Schedule as a treatment, procedure or supply for which benefits are payable;
c) performed by a Provider; and
d) assigned a procedure code which is generally accepted by the dental insurance industry.

When more than one method of treatment can be used to treat a condition, Policy benefits will be based on the Maximum Allowance of the least expensive method of treatment.

Deductible means the amount of out-of-pocket expense that must be incurred by an Insured Person for Covered Services before benefits are payable under the Policy.

Dental Charges Database (DCD) means a commercially available charge information database selected by us that provides historical information about the charges of Providers, by procedure code and geographic categories, all as determined and adjusted by the database supplier. The Dental Charges Database will be updated by us as information becomes available from the database supplier, up to twice each year. We may also modify the database to reflect our experience. We have the right to substitute or replace the selected database with a database or databases of comparable purpose, with or without notice.

Dental Hygienist or Denturist means a person who is:

a) licensed to perform specified dental procedures under the law of the jurisdiction in which the dental procedure is performed; and
b) operating within the scope of his or her license.

Dentist means a person who is:

a) licensed to practice dentistry under the law of the jurisdiction in which the dental procedure is performed; and
b) operating within the scope of his or her license.

Dependent means a citizen, permanent resident or lawful resident of the United States who is:

a) your Spouse or Registered Domestic Partner;
b) your or your Spouse or Registered Domestic Partner's natural born child, step child, adopted child, who is under age 26;
c) a child that you or your Spouse or Registered Domestic Partner are required to provide insurance for under the terms of a:
    1. Qualified Medical Child Support Order (QMCSO); or
    2. decree, judgment or order issued by a court of competent jurisdiction;
d) any other child who lives with you in a regular parent/child relationship and who qualifies as your dependent as defined in the United States Internal Revenue Code;
e) an Incapacitated person for whom you have been appointed legal guardian and who qualifies as your dependent as defined in the United States Internal Revenue Code.

A dependent does not include:

a) a child or Spouse or Registered Domestic Partner who is insured under the Policy as an Employee;
b) anyone who is a member of the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary duty of 31 days or less);
c) your divorced, legally separated, or former Spouse or Registered Domestic Partner;
d) a child who has reached the age of 26, unless the child is Incapacitated;
e) a child who is married, in a domestic partnership, or in a civil union partnership, or equivalent, as defined by your child's state of residence;
f) a child temporarily living in your home;
g) a child who has been legally adopted by another person; or
h) a child placed in your home by a social service agency which retains control over the child.

Eligibility Waiting Period means a continuous period of Active Work that you must satisfy before becoming eligible for insurance as described in the WHEN YOU BECOME ELIGIBLE FOR INSURANCE (ELIGIBILITY WAITING PERIOD) provision.

Employee means a person who is:

a) a citizen or permanent resident of the United States; or
b) lawfully and legally able to work in the United States pursuant to applicable federal and state laws; and
c) receiving compensation from the Policyholder for work performed for the Policyholder at:
    1. the Policyholder's usual place of business;
    2. an alternative work site at the direction of the Policyholder; or
    3. a location to which the employee must travel to perform the job.

An employee does not include a person:

a) who resides outside the United States for a period in excess of 12 consecutive months unless written approval has been received from our authorized representative in our home office;
b) working for the Policyholder on a seasonal or temporary basis; or
c) performing services for the Policyholder as an independent contractor, including persons for whom income is reported on a 1099 form or subject to the terms of a leasing agreement between the Policyholder and a leasing organization.

Expense means the charge incurred for a dental treatment, procedure or supply. Expense is considered incurred on the date a treatment or procedure is performed or a supply is furnished. Expense does not include any charge in excess of the charge that the Provider agreed to accept as payment in full.

Experimental or Investigational Device, Treatment or Procedure means a device, treatment or procedure which:

a) is not in general use in the practice of dentistry;
b) is under continued scientific testing or ongoing clinical trials;
c) does not have a measurable benefit for a dental injury, condition or disease; or
d) has not been proven to be safe and effective.

First Enrollment Period means the 31-day period following the day you or your Dependent becomes eligible for insurance under the Policy or any Prior Plan.

Incapacitated means a Dependent is continuously incapable of self-sustaining employment by reason of intellectual disability, developmental disability, mental illness, or physical disability.

If a Dependent child is Incapacitated and reaches an age where they are no longer considered eligible, they may continue to be insured as long as they remain Incapacitated. Proof of incapacity will be required within 60 days of a Dependent child reaching the limiting age. Proof of continued incapacity may be required by us, but not more frequently than once a year after the 2-year period following the child's attainment of the limiting age.

In-Network means any benefit, service, procedure, or supply furnished by a Provider who has agreed to accept a specific allowance as payment in full for Covered Services through participation in our Network.

Insured Person means you and/or your Dependent who is insured under the Policy.

Life Event means:

a) a change in Spouse or Registered Domestic Partner status;
b) a change in the number of your Dependents; or
c) a coverage change under any employer or group sponsored dental plan that you or your Dependents are covered.

Maximum Allowance means the maximum payment allowed for a Covered Service. As it applies to In-Network services, the Maximum Allowance will be equal to the In-Network contracted allowance for the Covered Service. As it applies to Out-Network services, the Maximum Allowance will be the lower of:

a) the Out-Network Provider's actual charge; or
b) the 90th percentile as identified by the Dental Charges Database (DCD). When there is minimal data available from the DCD for a Covered Service, we will determine the Out-Network Allowance by calculating the unit cost for the applicable service category using the DCD, and multiplying that by the relative value of the Covered Service based upon a commercially available relative value scale selected by us. In the event of an unusually complex Covered Service, a Covered Service that is a new procedure or a Covered Service that otherwise does not have a relative value that is in our determination applicable, we will assign one. In no event will the Out-Network Allowance be more than the amount billed by the Provider or the amount for which you are responsible. The term "Out-Network Allowance" may not reflect the actual charges of the Provider and does not take into account the Provider's training, experience or category of licensure. You may be charged by your Provider for any fee not reimbursed by the Out-Network Allowance.

Medically Necessary means a dental treatment, procedure or supply which is:

a) provided for the prevention, diagnosis, or direct treatment of a dental injury, condition or disease; and
b) appropriate and consistent with the symptoms and findings or diagnosis and treatment of the Insured Person's dental injury, condition or disease.

The fact that your Provider orders, prescribes or renders treatments, procedures or supplies does not automatically mean such treatments, procedures, or supplies are Medically Necessary.

Natural Tooth means any tooth or part of a tooth that is organic and formed by the natural development of the body (i.e., not manufactured). Organic portions of a tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp (nerve).

Network means a credentialed group of dental Providers who have agreed to provide Covered Services to Insured Persons at a negotiated allowance.

Out-Network means any benefit, service, procedure, or supply furnished by a Provider who does not participate in the Network and has not agreed to accept a negotiated allowance as payment in full for Covered Services performed.

Our, We, Us means United of Omaha Life Insurance Company.

Percentage Payable means the percentage of the Maximum Allowance payable for Covered Services after satisfaction of any applicable Deductibles and waiting periods.

Plan means the Policy and any of the following coverages, including coverage which is declared to be excess to all other coverages, which provide benefit payments or services to an Insured Person for hospital, medical, surgical, dental, prescription drug or vision care:

a) group, blanket or franchise insurance (except student accident insurance);
b) prepayment coverage on a group basis, including HMOs (Health Maintenance Organizations);
c) coverage under a labor-management trustee plan, a union welfare plan, an employer organization plan or an employee benefits plan;
d) coverage under government programs, other than Medicare or Medicaid, and any other coverage required or provided by law;
e) other arrangements of insured or self-insured group coverage.

Plan Administrator means the person or entity designated as the plan administrator for the Policyholder's group dental insurance plan.

Policyholder means Trinity Management Services.

Policy means the group policy issued to the Policyholder by us, including this Certificate.

Policy Anniversary means January 1 of each Policy Year.

Policy Effective Date means January 1, 2025.

Policy Year means the period of January 1 through December 31.

Policy Year Maximum Benefit means the amount shown as the "Policy Year Maximum Benefit" in the GENERAL PROVISIONS section of the Schedule.

Primary Plan means the Plan that pays benefits prior to payment of benefits by a Secondary Plan in accordance with the terms of the COORDINATION OF BENEFITS (COB) provision.

Prior Plan means any similar insurance policy:

a) replaced by insurance under part or all of the Policy; and
b) in effect and maintained or sponsored by the Policyholder on the day before the Policy Effective Date.

Provider means a Dentist, Denturist, or Dental Hygienist.

Qualified Beneficiary means any individual who, on the day before the qualifying event, is an Insured Person under the Policy. Qualified Beneficiary also includes a child who is born or is placed for adoption with you during the period of continued coverage.

Registered Domestic Partner means a pair of adults who have registered themselves as domestic partners in accordance with state law.

Secondary Plan means the Plan that pays benefits after benefits have been paid by the Primary Plan in accordance with the terms of the COORDINATION OF BENEFITS (COB) provision.

Serious Chronic Condition means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Sound Natural Tooth means a Natural Tooth, which is fully restored to function, does not have any decay, is not more susceptible to injury than a virgin tooth, and is without periodontal disease.

Spouse means the person to whom you are legally married.

Subsequent Enrollment Period means the period of time designated for enrollment by the Policyholder and agreed to in writing by our authorized representative in our home office.

Written Request means a request that is signed, dated and submitted to the Policyholder or us. The request must be on a form we supply or be in a form and content acceptable to us.

*You, Your, Yourself m*eans the Employee who may become eligible or insured under the Policy.

If a problem occurs, please first contact the Policyholder or your benefits administrator. If, after doing so, you still have a question or concern, you may contact us at:

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-927-9197
www.mutualofomaha.com

The Department of Insurance should be contacted only after the contacts between you and the Policyholder or your benefits administrator and your insurance company or its representatives have failed to produce a satisfactory solution to the problem.

To contact the Department of Insurance, write or call:

Consumer Division
Department of Insurance, Los Angeles Office
300 South Spring Street
Los Angeles, California 90013
1-800-927-4357

TDD: 1-800-482-4TDD (4833)
www.insurance.ca.gov

ADDITIONAL SUMMARY PLAN DESCRIPTION INFORMATION

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to eligible participants in an employee benefits plan. The employee benefits plan maintained by the Policyholder shall be referred to herein as the "Plan."

This document, in conjunction with Your Certificate, is Your ERISA Summary Plan Description for the insurance benefits described herein. However, this Certificate does not include complete information regarding the election changes which may be permissible under the Policyholder's Internal Revenue Code Section 125 cafeteria plan. Your plan administrator will provide You with information regarding the election changes that are permissible under the cafeteria plan.

Contributions are made by the Policyholder and by participants. Contributions are based on the amount of insurance premiums necessary to provide Plan coverage.

The benefits under the Plan are fully insured by Us under a group insurance policy issued by Us. Benefits under the Policy are guaranteed to the extent all Policy provisions are met and subject to all terms and conditions of the Policy (including, but not limited to, all exclusions, limitations and exceptions in the Policy). Our home office is located at Mutual of Omaha Plaza, Omaha, NE 68175.

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

The Employer Identification Number (EIN) is: 94-2553354
The Plan Number is: 502

PLAN ADMINISTRATOR

The Plan is provided through and administered by:

Trinity Management Services
1145 market st
ste 1200
San Francisco, CA 94103
Phone: (650) 284-6222

AGENT FOR SERVICE OF LEGAL PROCESS

The agent for service of legal process upon the Plan is:

Trinity Management Services
1145 market st
ste 1200
San Francisco, CA 94103
Phone: (650) 284-6222

PLAN YEAR

Each 12-month period beginning on January 1 is a "plan year" for the purposes of accounting and all reports to the U.S. Department of Labor and other regulatory bodies.

STATEMENT OF ERISA RIGHTS

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

a) Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

b) Prudent Actions by Plan Fiduciaries

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

c) Enforce Your Rights

If Your claim for a benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in 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.

d) Assistance with Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN DISCLOSURES

You are entitled to request from the Plan Administrator, without charge, information applicable to the Plan's benefits and procedures. In addition, Your Certificate includes, as applicable, a description of:

a) employee eligibility requirements;
b) when insurance ends;
c) state or federal continuation rights; and
d) claims procedures.

PLAN CHANGES

The persons with authority to change, including the authority to terminate, the Plan on behalf of the Policyholder are the Policyholder's Board of Directors or other governing body, or any person or persons authorized by resolution of the Board or other governing body to take such action. Please refer to the provision in Your Certificate entitled "Changes in the Insurance Contract" for information about how the Policy can be changed. The Policyholder's benefits area is authorized to apply for and accept the Policy and any changes to the Policy on behalf of the Policyholder.

Group Dental Benefits

Trinity Management Services

Group Number: G000CFQD

United of Omaha Life Insurance Company

Home Office:
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175