Summary of Benefits
CO-INSURANCE/IN AND OUT - MAX PLAN

	In-Network Fee Schedule	Out-of-Network R & C
Preventive		
Diagnostic-Preventive Preventive, Preventive-Basic (Sealants, Space Maintainers) Exams, Cleanings (2 per year), Fluoride, X-rays, etc...	100%	100%
Basic		
Adjunctive Services-Basic Diagnostic-Basic, Oral and Maxillofacial Surgery, Restorative-Basic	80% Deductible Applies	80% Deductible Applies
Major		
Adjunctive Services-Major Anesthesia Services- Major, Endodontics, Implant Services, Periodontics, Prosthodontics-Fixed, Prosthodontics-Removable, Restorative-Major	50% Deductible Applies	50% Deductible Applies
Orthodontics		
Orthodontics Max Age Through: 18	50%	50%
Maximums		
Preventive, Basic, & Major Per Member: Per Effective Date **Maximum Rollover Provision Applies**. Member's Annual Maximum increases incrementally each year, until Annual Maximum reaches $2,000.00. See Schedule of Benefits. Orthodontic Lifetime Maximum	$1000.00 Initial Annual Maximum $1000 Lifetime Max	$1000.00 Initial Annual Maximum $1000 Lifetime Max
Deductibles		
Per Person / Per Family Per Member: Per Effective Date	$50\150	$50\150
Specialists		
	Specialists - Plan payment details on the following page.	

Please refer to the next page for additional plan notes.

Platinum Network Advantages

Exceptional network coverage is just the beginning. Visit any dentist you choose. Your Dental Select dental plan offers the greatest out-of-pocket savings advantage available when you receive care from a contracted provider.

Platinum Network Cost Savings

Contracted (participating) general dentists. Contracted general dentists accept the Platinum[1] fee schedule as payment in full. There is no balance billing.

Contracted (participating) specialists.

Orthodontist specialists. Contracted orthodontia specialists have agreed to discount their usual charges for eligible orthodontic services. If orthodontia services are covered by your Plan (refer to your Summary of Benefits), the Plan payment is based on the contracted fee schedule. You are responsible for the difference between the discounted fee and the Plan payment (if any).

All other specialists. Plan payments for covered services are based on the contracted fee schedule. Contracted specialists (except contracted orthodontists) accept the contracted fee schedule as payment in full. There is no balance billing.

Use of a contracted general dentist or specialist does not guarantee that all charges will be covered under the Policy. All charges are subject to all terms and conditions of the Policy.

Fee Schedules are subject to change upon notification.

Access to Out-of-Network Options

Non-contracted (non-participating) general dentists & specialists. Plan payments to non-contracted providers are based on R&C (*the reasonable & customary charge for the area where the expense is incurred*). Charges above the Plan's payment are your responsibility.

[1] ***For Minnesota residents only:*** Contracted general dentists and contracted specialists accept the Premier Network fee schedule as payment in full. There is no balance billing.

ACE American Insurance Company
1601 Chestnut Street
Philadelphia, PA 19103

Certificate of Insurance

ACE USA (herein called We, Our or Us) certifies that the Insureds listed on the Certificate below are covered under the Policy issued to the Policyholder.

YOUR INSURANCE CERTIFICATE
GENERAL INFORMATION
About Your Insurance

This Certificate explains the plan of insurance underwritten by ACE USA. Read it closely to become familiar with Your coverage.

Important Notice

Benefits are payable only for expenses incurred while Your insurance is in force.

No agent has the right to change the Policy or to waive any part of it.

The Policy, under which this Certificate is issued, may be amended or canceled at any time as stated in its provisions. Such an action may be taken without the consent of or notice to any person who claims rights or benefits under the Policy.

The insurance under the Policy does not take the place of nor does it affect any requirements for coverage by Worker's Compensation or a similar type of insurance.

Signed for ACE American Insurance Company at Philadelphia, Pennsylvania.

JOHN J. LUPICA, President

REBECCA L. COLLINS, Secretary

DENTAL INSURANCE CERTIFICATE

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SCHEDULE OF BENEFITS

MAXIMUM ROLLOVER PROVISION:

**** Maximum Rollover Provision Only Included if so Indicated on Summary of Benefits. (Does not apply to orthodontic maximum.)***

This provision gradually increases the amount of the Insured's annual maximum each consecutive year of coverage under the Policy until such time as the annual maximum reaches two thousand dollars. Increases to the annual maximum are automatically applied each year on the anniversary of Your effective date on this Policy. The amount by which the Insured's annual maximum is increased in any given year is determined by the initial annual maximum established by Your employer at the time of Your enrollment on the Policy.

The Insured's annual maximum is increased by $100.00 on the first anniversary of Your effective date; on the second anniversary of Your effective date, the Insured's annual maximum is increased by $200.00; on the third anniversary of Your effective date, the Insured's annual maximum is increased by $300.00; and so forth, with the yearly increase amount applied to the Insured's annual maximum increasing by an additional $100.00 each year, ***until such time as the Insured's annual maximum reaches $2,000.00 at which point no further increases are applied***. **Upon the Insured's annual maximum reaching $2,000.00 (whether this occurs on the first, second, or any subsequent anniversary of coverage under the Policy), no further increases will be applied to the Insured's annual maximum.**

Here are two examples. Your increase will be calculated based on the initial annual maximum shown in the Summary of Benefits:

Example I. If Your initial annual maximum is $1,250.00:	**Example II. If Your initial annual maximum is $1,700.00:**
Year 1: Annual Maximum = $1,250.00 Year 2: Annual Maximum = $1,350.00 Year 3: Annual Maximum = $1,550.00 Year 4: Annual Maximum = $1,850.00 Year 5: Annual Maximum = $2,000.00 Beyond Year 5: Annual Maximum =$2,000.00	Year 1: Annual Maximum = $1,700.00 Year 2: Annual Maximum = $1,800.00 Year 3: Annual Maximum = $2,000.00 Beyond Year 3: Annual Maximum = $2,000.00

All benefits are based on a contracted fee-for-service schedule.

Contracting General Dentist Services: Participating General Dentists accept the contracted fee schedule as payment in full.

Contracting Provider Services: Participating providers accept the contracted fee schedule as payment in full.

Contracting Specialist Services: Services rendered by a Contracting Specialist will be reimbursed as follows: after the deductible, We pay Contracting Specialists according to the contracted fee schedule.

Use of a Contracting Provider does not guarantee that all charges will be covered under the Policy. All charges are subject to all terms and conditions of the Policy.

Non-Contracting Provider Services: Non-contracting providers may not accept the contracted fee schedule as payment in full. Charges above the contracted fee schedule are the Insured's responsibility.

Eligible Expenses will be paid at benefit levels for Non-Contracting Providers if an Insured incurs any Eligible Expenses:

1. for services of a provider who is no longer a Contracting Provider; or
2. when the Insured elects not to use the services or supplies of the Contracting Provider.

COVERED SERVICES

The following is the list of Covered Services for which benefits are payable under the policy. Procedures not listed below are not covered or, may be covered at Our sole option if such procedures are considered to be appropriate and are performed according to accepted standards of dental practice for the condition. All services are subject to review for necessity; X-rays, charting, and/or records may be required to determine if any procedure is covered.

Class A. Preventive Services Include: ***May be subject to a waiting period. Refer to Summary of Benefits.***

1. routine examinations and cleanings – 2 per year (in conjunction with all other exams);
2. topical fluoride (up to age 16) – 1 every 12 months;
3. panoramic* *(age 6 & over)* or full mouth series x-rays* *(age 11 & over)* – 1 every 60 months;
4. bitewings x-rays *(age 11 and over)* – 8 total per 12 months;
5. periapical x-rays;
6. occlusal x-ray – 1 upper and 1 lower every 24 months;
7. space maintainers (*up to age 16) – to preserve* space between teeth for premature loss of a primary baby tooth. **This does not include use for orthodontic treatment**;
8. sealants on permanent molars *(up to age 16)* – every 36 months.

****Panoramic or full mouth series x-rays may be covered under Major Services. Refer to Summary of Benefits.***

Class B. Basic Services Include: ***May be subject to a waiting period. Refer to Summary of Benefits.***

1. oral surgery – simple extraction of teeth; frenectomy, incision and drainage of intraoral abscess; extraction of impacted teeth; surgical exposure of teeth; alveolectomy; alveoplasty; excision of pericoronal gingiva, exostosis, hyperplastic tissue; reimplantation and repositioning of natural tooth;
2. non-routine exams and consultations - 2 per year (in conjunction with all other exams);
3. fillings of amalgam, silicate, acrylic, synthetic porcelain and composite filling materials (certain exclusions apply, see Expenses Not Covered);
4. pin retention of fillings.

Class C. Major Services Include: ***May be subject to a waiting period. Refer to Summary of Benefits.***

1. crown build-up; post and core;
2. recementing inlays, crowns and bridges;
3. repair of dentures or bridges;
4. general anesthesia, including intravenous sedation:
   a. age 7 & under - once per calendar year, up to $150;

b. age 8 & over, for the extraction of impacted teeth, based on necessity and not for anxiety management, up to $150 per year;

5. crowns, bridges, inlays, onlays, dentures and gold fillings - every 60 months (age restrictions may apply; additional lab fee may be charged by provider for higher metals and porcelain that is not covered by the plan);
6. endodontic treatment*: root canal therapy *(age restrictions apply)*; pulpotomy; pulpal therapy; apicoectomy; apexification/recalcification; root amputation; hemisection; intentional reimplantation; retrograde fillings;
7. periodontic services*:
   a. perio maintenance - 2 per year (in lieu of preventive cleaning);
   b. root scaling and planing (once per quadrant of mouth in any 36 month period);
   c. gingivectomy, gingival curettage;
   d. osseous surgery including flap entry and closure;
   e. pedical or free soft tissue grafts;
   f. full mouth debridement - once per lifetime (limited services available on same date of service).
8. addition of teeth to existing partial denture;
9. relining or rebasing of existing removable dentures - 1 per 24 months;
10. implants, supported fixed and removable prosthetic (crowns, bridges, partials, dentures) – a restoration that is retained, supported and stabilized by an implant – (This procedure receives an optional treatment benefit equal to the least expensive professionally acceptable treatment. The additional fee is the patient's responsibility);
11. occlusal guards for bruxism only - 1 per 24 months;
12. stainless steel crowns - 1 per 24 months.

Endodontic and Periodontic services may be covered under Basic Services. Refer to Summary of Benefits.

Class D. Orthodontia Services: ***May be subject to a waiting period. Refer to Summary of Benefits.*** ***Orthodontia Services Only Included if Indicated on Summary of Benefits.**

1. appliance therapy
   a. diagnostic records – (cephalometric film, panoramic or full mouth x-rays, diagnostic casts, diagnostic photographs.)
   b. removable, fixed or cemented appliance for orthodontic treatment including impressions, installations, & adjustments while covered under the plan.

No coverage or limited coverage for orthodontic treatment which began prior to the effective date of coverage.

EXCLUSIONS

EXPENSES NOT COVERED: No benefits will be paid for expenses incurred:

1. for services and supplies not listed in the Summary of Benefits, not recognized as essential for the treatment of the condition according to accepted standards of practice or considered experimental.
2. for cosmetic procedures, including but not limited to veneers and bleaching of teeth and procedures performed primarily for cosmetic reasons.
3. for services related to, performed in conjunction with, or resulting from a non-covered procedure.
4. for charges in excess of the contracted Fee-for-Service schedule or the Reasonable and Customary rate, whichever applies.

5. for any treatment program which began prior to the date the Insured is covered under the Policy.
6. for crowns, inlays and onlays on teeth that can be restored by direct placement materials.
7. for the replacement of crowns, bridges, inlays, onlays or prosthetic appliance within 5 years from the date of last placement.
8. for service or supplies payable under any medical expense, auto or no-fault plan.
9. for any condition covered under any Worker's Compensation Act or similar law.
10. for services applied without cost by any municipality, county or other political subdivision or for which there would be no charge in the absence of insurance.
11. for services that are applied toward the satisfaction of a Deductible, if any.
12. for services subject to a waiting period.
13. for charges resulting from changing from one provider to another while receiving treatment, or from receiving treatment from more than one provider for one dental procedure to the extent that the total charges billed exceed the amount incurred if one provider had performed all services.
14. for hospital facility charges for any dental procedure, including but not limited to: emergency room charges, surgical facility charges, hospital confinement.
15. for drugs or the dispensing of drugs.
16. for oral hygiene instruction; plaque control; acid etch; prescription or take-home fluoride; broken appointments; completion of a claim form; OSHA/Sterilization fees (Occupational Safety & Health Agency); or diagnostic photographs (except for orthodontic purposes).
17. for implants (unless included in the Covered Services); myofunctional therapy; athletic mouthguards; precision or semi-precision attachments; treatment of fractures, cysts, tumors, or lesions; maxillofacial prosthesis; orthognathic surgery; TMJ dysfunction or cleft palate (except as provided for under the Mandated Coverage Provision in Minnesota); or anodontia.
18. for orthodontia, unless included within the Summary of Benefits.
19. for services to replace teeth that were missing (extracted or congenitally) prior to the effective date of coverage on Our Plan. This limitation ends after 36 months of continuous coverage on the Plan. Abutment teeth will be reviewed for eligibility of prosthetic benefits. This exclusion does not apply if the device covers one or more natural teeth lost or extracted while covered under the Plan, or if the prosthetic device was in place when the policy became effective.
20. for composite, resin, or white fillings on posterior primary teeth.
21. for the replacement of a filling within 24 months of placement, unless for specific health reasons.
22. for the replacement of retainers.
23. for sealants not applied to permanent molar; applied at age 16 or older; applied 3 years from a previous sealant application; applied to a decayed tooth.
24. for lab fees for higher metals or porcelain crowns, bridges, inlays or onlays.
25. during travel or activity outside the United States.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit Us from providing insurance including, but not limited to, the payment of claims.

DEFINITIONS

These definitions apply when the following terms are used in this Certificate

ADA CODE: means the American Dental Association Code assigned to a particular dental procedure.

CONTRACTING GENERAL DENTIST: means a licensed dentist who agrees to provide services to a specific pool of patients at an agreed upon fee-for-service rate.

CO-PAYMENT / DEDUCTIBLE: means the amount you must pay toward the cost of an ELIGIBLE EXPENSE.

COURSE OF TREATMENT: means all treatment and procedures performed in the oral cavity under a plan of treatment during one or more sessions that are the result of the same initial diagnosis. It also includes any complications during such treatment.

CUSTOMARY FEE: the fee level determined by the administrator of a dental benefit plan from actual submitted fees for a specific dental procedure to establish the maximum benefit payable under a given plan for that specific procedure.

DENTAL HYGIENIST: means a person who works under the supervision of a Dentist/Physician and who is currently licensed to practice dental hygiene.

DEPENDENT: means any of the following persons:

1. Your legal spouse.
2. Each unmarried child, from birth to age 26.
3. Each unmarried child at least 26 years of age:
    a. who is dependent upon You for support because he is incapable of self-sustaining employment by reason of mental or physical handicap;
    b. who was incapacitated and insured under the Policy on his 26th birthday; and who continues to be incapacitated beyond his 26th birthday. You must give Us proof of the incapacity and dependency within 30 days of the child's 26th birthday. We may require further proof at any time after that. We may not require this more often than annually after two years.

A child, for eligibility purposes, includes an Insured's natural child, stepchild, adopted child, or grandchild who is dependent on the Insured for federal income tax purposes at the time application for coverage of the child is made.

DOMESTIC PARTNER: means a person who:

1. Shares the Insured's permanent residence;
2. Has resided with the Insured for at least 12 months prior to the date of enrollment and is expected to continue to reside with the Insured indefinitely;
3. Is financially interdependent with the Insured in each of the following ways:
    a. By holding one or more credit or bank accounts, including a checking account, as joint owners;
    b. By owning or leasing their permanent residence as joint tenants;
    c. By naming, or being named by, the Insured as a beneficiary of life insurance or under a will;
    d. By each agreeing in writing to assume financial responsibility for the welfare of the other;
4. Has signed a Domestic Partner declaration with the Insured, if the Insured resides in a jurisdiction which provides for Domestic Partner declarations;
5. Has not signed a Domestic Partner declaration with any other person within the last 12 months;
6. Is older than 18 years old, but no more than 70 years old;
7. Is not currently legally married to any other person; and
8. Is not a blood relative any closer than would prohibit legal marriage.

ELIGIBLE EXPENSES: means those dental services described in this Certificate as being eligible for coverage.

EMERGENCY: means a dental condition of an unforeseen nature which requires immediate dental treatment.

EMPLOYEE: a permanent full-time Employee of the employer working required hours per week on a regular basis.

INSURED: means You and Your Dependents who meet the eligibility requirements of the Policy and for whom the applicable premium has been paid.

NON-CONTRACTING DENTIST: means a licensed dentist who has not agreed to provide services to a specific pool of patients at an agreed upon fee-for-service rate.

POLICY: means the Policy issued to the Policyholder.

QUALIFYING EVENT: means one of the following life status changes: Marriage, Divorce, or Legal Separation, Birth of a Child or Adoption of a Child, Loss of Employment, New Employment, Death of Insured.

REASONABLE FEE: the fee charged by a dentist for a specific dental procedure that has been modified by the nature and severity of the condition being treated and by any medical or dental complications or unusual circumstances, and therefore may differ from the dentist's "usual" fee or the benefit administrator's "customary" fee.

REASONABLE AND CUSTOMARY (R&C): means the reasonable and customary charges for the area where such expenses are incurred.

SPECIALIST: means a licensed dentist who is board certified in one or more of the following specialties: Endodontics, Periodontics, Pedodontics, Prosthodontics, Oral Surgery, Orthodontics and any other board certified specialty outside of general dentistry.

SUMMARY OF BENEFITS: a description of Your benefits including coverage level for services, deductibles, maximums, waiting periods, etc.

USUAL AND CUSTOMARY: means the usual, customary and reasonable charges for the area where such expenses are incurred.

WAITING PERIOD: the time period between the effective date of dental coverage and the date when a member is eligible for benefits in a specific class.

WE, OUR, US: means ACE American Insurance Company.

YOU, YOUR, YOURS: means the certificate holder.

CONDITIONS FOR INSURANCE

WHO IS ELIGIBLE FOR COVERAGE: You and Your Dependents are eligible to be insured on the later of: 1) the Policy Effective Date; or 2) the day after you complete the Eligibility Waiting Period, if later.

We maintain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

ENROLLMENT: You and Your Dependents may enroll for coverage within 31 days of becoming eligible for coverage through Your employer, during Your employer's open enrollment period or, within 31 days of a Qualifying Event.

EFFECTIVE DATE: You and your Dependents are covered on the later of:

1. the date You and Your Dependents become eligible for coverage provided You enroll within 31 days of that date;
2. the first day of the month following the Employer's annual renewal date if You fail to enroll You and/or Your Dependents within 31 days of that date You and/or Your Dependents first become eligible; or
3. the date You first acquire a new Dependent, provided You enroll within 31 days of that date.

NEWBORN INFANT COVERAGE: A Dependent child born is covered from the moment of birth while the policy is in force. A notice of birth together with the premium must be submitted to Us. This must be done within 31 days after the date of birth. Coverage for Dependent children includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities or prematurity.

ADOPTED CHILDREN COVERAGE: A Dependent child placed with You for adoption is covered from the date of such placement while the policy is in force. In the case of adoption of a newborn child, coverage will begin from the moment of birth if placement for adoption occurs within 31 days of the child's birth. Such coverage will continue, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

A notice of placement for adoption together with the premium must be submitted to us. This must be done within 31 days after the date of such placement.

COURT OR ADMINISTRATIVE ORDER: When a parent is required by court or administrative order to provide health coverage for a child, and the parent is eligible for Dependent coverage under the plan, We will not deny enrollment of the child on the grounds that the child:

1. was born out of wedlock and is entitled to coverage though the non-custodial parent;
2. was born out of wedlock and the custodial parent seeks enrollment for the child under the custodial parent's plan;
3. is not claimed as a dependent on the parent's federal tax return; or
4. does not reside with the parent or in the plan's service area.

DOMESTIC PARTNER PROVISION: An Insured may elect coverage for a Domestic Partner if all of the following conditions are met:

1. The Insured has not been married to any person within the past 12 months.
2. The Domestic Partner is the only person meeting the Policy's definition of "Domestic Partner" with respect to the Insured.
3. The Insured and Domestic Partner furnish a notarized affidavit/signed statement reflecting these requirements, and an agreement to notify the Company if the requirements cease to be met, on a form acceptable to the Company.

In addition to the above requirements, consent of either party to the Domestic Partner relationship must not have been obtained by force, duress, or fraud.

To obtain insurance for a Domestic Partner, the Insured must request coverage in writing and agree to make any required premium contribution. Insurance will be effective on the first day of the month after we receive a signed request and all required information.
The amount of insurance with respect to any Domestic Partner is as shown in the Schedule.

PREMIUMS: Premiums are payable on a monthly basis, unless We agree to some other mode of payment. Premium must be paid to Us at Our Home Office or to Our authorized administrator. The payment of any premium will keep Your coverage in force to the next premium due date, subject to the Termination provision.

TERMINATION: You and Your Dependents may terminate your coverage during Your employer's open enrollment period or, within 31 days of a Qualifying Event.

YOUR INSURANCE ENDS: Insurance for You and Your Dependents will end on the earliest of:
1. the last day You cease to be eligible (contact your employer for any Voluntary Continuation option);
2. the last day Your Dependent ceases to be a Dependent, as defined;
3. the last day of the month for which a premium has been paid; or
4. the date the Policy ends.

If Your coverage ends it will not prejudice any existing claim. If You terminate Your insurance and wish to re-enroll at a later date, We reserve the right to require a two year waiting period. Your two year waiting period will begin on the date You first terminated Your insurance.

VOLUNTARY TERMINATION: If You voluntarily end Your insurance without a qualifying event and re-enroll at a later date, Your re-enrollment waiting period is 2 years and begins on the date Your coverage first ended.

GRACE PERIOD: If any premiums are not paid by the Premium Due Date, a Grace Period of 31 days will be granted for the payment of the required premiums. Coverage under the Policy will remain in force during the Grace Period. If the required premiums are not paid during the Grace Period, insurance will end as of the last day of the period for which premiums were paid. You will be liable to Us for any unpaid premium for the time coverage under the Policy was in force.

RECOVERY OF OVERPAYMENT: If benefits are overpaid, or paid in error, We have the right to recover the amount overpaid, or paid in error, by any of the following methods:
1. A request for lump sum payment of the amount overpaid, or paid in error;
2. Reduction of any proceeds payable under the Policy by the amount overpaid, or paid in error.

DENTAL INSURANCE

ELIGIBLE EXPENSES: We will pay for Eligible Expenses You incur for Yourself or on behalf of Your insured Dependent. Expenses must be incurred while the Policy is in force and You are covered by the Policy. The description of Eligible Expenses is shown in the Summary of Benefits. To be an Eligible Expense, the dental service or procedure must be performed by:
1. a Dentist;
2. a Physician; or
3. a Dental Hygienist.

EXPENSES INCURRED: An Eligible Expense is considered incurred on the following dates:
1. For dentures - the date the first impression is taken;

2. For crowns, inlays and onlays - the date the teeth are first prepared.
3. For root canal therapy - the date the pulp chamber is opened.
4. For periodontal surgery - the date surgery is performed.
5. For orthodontic services - Benefit is considered as follows:
    a. Records- on the date the service is performed;
    b. Initial banding - on the date bands are inserted;
    c. Monthly treatments - on the date the service is performed.
6. For all other services - the date the service is performed.

MAXIMUM CALENDAR/CONTRACT YEAR LIMIT: The maximum limit payable for all Eligible Expenses in any calendar/contract year is shown in the Summary of Benefits. The Maximum Calendar/Contract Year Limit, if any, will apply to each person covered under the Policy.

DEDUCTIBLE: The lifetime and calendar/contract year Deductible, if any, is shown in the Summary of Benefits. The Deductible is an amount of charges You must incur for Yourself or on behalf of Your insured Dependent before We start paying benefits.

CONTRACTING GENERAL DENTIST SERVICES: Contracting General Dentists accept the contracted fee schedule as payment in full. The negotiated fees are subject to change without notice. Services not listed in the Provider's contracted fee schedule are available on a fee-for service basis and are the patient's full responsibility.

Use of a Contracting General Dentist does not guarantee that all charges will be covered under the Policy. All charges are subject to all terms and conditions of the Policy.

CONTRACTING SPECIALIST SERVICES: A Specialist is a licensed dentist who is board certified in one or more of the following specialties: Endodontics, Periodontics, Pedodontics, Prosthodontics, Oral Surgery, Orthodontics, and any other board certified specialty outside of general dentistry.

Services rendered by a Contracting Specialist will be reimbursed as follows: after the deductible, We pay Contracting Specialists according to the contracted fee schedule. Use of a Contracting Specialist does not guarantee that all charges will be covered under the Policy. All charges are subject to all terms and conditions of the Policy.

NON-CONTRACTING GENERAL DENTIST & SPECIALIST SERVICES: Non-Contracting Dentists and Specialists do not accept Our contracted fee schedule as payment in full. Services will be reimbursed as stated in the Summary of Benefits. The fact that a Dentist, Hospital, or other Provider may prescribe, order, recommend, or approve a service or supply, does not, of itself, make it Medically Necessary or make the charge an allowable expense. We determine if a service or supply is covered in accordance with established Plan benefit and eligibility criteria and policies.

PRE-DETERMINATION REVIEW: We recommend You receive a pre-determination if the Course of Treatment is expected to exceed $300. The Dentist's treatment plan consisting of a description of the planned treatment with estimated charges and diagnostic x-rays is required for the review. We will determine Eligible Expenses and state how much We will pay for the treatment. Our determination may suggest an alternate, less expensive Course of Treatment if it will produce professionally-satisfactory results. Failure to obtain a pre-determination may result in additional out-of-pocket expenses for You if an alternate, less expensive treatment is available but not used.

ALTERNATE BENEFIT: If: 1) We determine that a less expensive alternate procedure, service or Course of Treatment can be performed in place of the proposed treatment to correct a dental

condition; and 2) the alternative treatment will produce a professionally satisfactory result; then the maximum We will allow will be the charge for the less expensive treatment.

COBRA CONTINUATION OF BENEFITS

(Employers of 20 or more Employees)

APPLICABILITY: Federal Law requires that employers of 20 or more Employees offer temporary extension of health coverage to Qualified Beneficiaries of Employees employed at least 50% of the preceding year when coverage would otherwise end because one or more of the Qualifying Events listed below occurs. Under COBRA, a Qualified Beneficiary is any individual who, on the day before a Qualifying Event, is covered under the Policy and is not 1) already covered under the Policy by reason of another individual's election of COBRA Continuation Benefits, or 2) entitled to Medicare benefits under Title XVIII of the Social Security Act.

QUALIFYING EVENT: For purposes of coverage under COBRA, the term Qualifying Event means, with respect to any Insured, any of the following events that, but for the continuation coverage required under the law, would result in the loss of coverage for a Qualified Beneficiary.

Qualifying Event	**Coverage Continuation Period**
• Death of an Insured	36 months
• Termination of employment for any reason except gross misconduct, or the reduction in hours that would result in loss of coverage	18 months*
• Divorce or legal separation	36 months
• The Insured becomes eligible for Medicare	Dependents allowed 36 months
• An insured Dependent no longer meets the eligibility requirements	36 months

*Coverage may be continued for an additional 11 months if the Qualified Beneficiary:

1. Is determined disabled for Social Security purposes at the time of the Qualifying Event or within 60 days after continuation coverage begins; and
2. Notifies the plan administrator within 60 days from determination but before the 18-month continuation period begins.

Beneficiaries may be covered by more than one Qualifying Event. However, in no event may the total continuation period exceed 36 months from all Qualifying Events.

NOTICE AND ELECTION: Insured are responsible for notifying their employer in the case of divorce, legal separation, cessation of dependency or determination of disability by the Social Security Administration. The employer must notify the plan administrator of the Qualifying Event. The employer must notify the Qualified Beneficiaries of their COBRA election rights. The period during which the Qualified Beneficiary must elect or decline continuation of coverage under COBRA ends not earlier than 60 days after the later of 1) the date that coverage would end under the Policy by reason of a Qualifying Event, or 2) the date the Qualified Beneficiary receives notice of their COBRA election rights from the plan administrator.

PREMIUM PAYMENT: The Qualified Beneficiary must pay to the employer the required monthly premium. Any Grace Period applying to the employer will also apply to the Qualified Beneficiary, except for the first premium payment. Payment of premium for coverage under the period preceding the election must be made within 45 days of the date of the election.

TERMINATION OF CONTINUED BENEFITS: Benefits continued under COBRA will end on the first date that one of the following events occurs:

1. The premium for continued coverage is not paid within 31 days from when it is due;
2. The Qualified Beneficiary becomes covered under another group medical plan providing the same or similar benefits, if that plan does not contain any exclusion or limitation on any pre-existing conditions of the Qualified Beneficiary;
3. The Qualified Beneficiary becomes eligible for Medicare;
4. The Qualified Beneficiary, who is divorced from an insured Employee, remarries and is covered under the new spouse's medical plan; or
5. The employer no longer provides dental benefits of any kind.

PREMIUMS: Premiums are payable on a monthly basis, unless We agree to some other mode of payment. Premium must be paid to Us at Our Home Office or to Our authorized administrator. The payment of any premium will keep Your coverage in force to the next premium due date, subject to the Termination Provision.

GRACE PERIOD: If any premiums are not paid by the Premium Due Date, a Grace Period of 31 days will be granted for the payment of the required premiums. Coverage under the Policy will remain in force during the Grace Period. If the required premiums are not paid during the Grace Period, insurance will end as of the last day of the period for which premiums were paid. You will be liable to Us for any unpaid premium for the time coverage under the Policy was in force.

COORDINATION OF BENEFITS

COORDINATION of BENEFITS (COB) and OTHER RECOVERY SYSTEMS

If an Insured is also covered under one or more other plans, this COB provision will apply. COB is the process of determining which of the two or more plans has primary responsibility to pay first and the manner and extent to which the other plans pay or contribute.

DEFINITIONS: For the purpose of this COB provision:

Allowable Expense: means that amount on which this Plan would base its benefit for any dental charge in the absence of any other coverage when a Plan provides benefits in the form of services, the cash value of each service will be treated as both an Allowable Expense and a benefit paid.

Plan: means a form of coverage, including coverage under this Policy that provides benefits or services for dental care or treatment. "Plan" includes group insurance and group subscriber contracts; uninsured arrangements of group or group-type coverage; group or group-type coverage through HMOs and other prepayment plans; group-type contracts; medical payments paid by group, group-type and individual automobile "no-fault" medical payment contracts; "Plan" will be treated separately for each contract or other program for benefits or services. "Plan" will be treated separately for that part of a Plan which reserves the right to coordinate with benefits or services of other Plans and that part which does not.

Primary Plan: means a Plan whose benefits are determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if: 1) it has no order of benefit determination; or 2) all Plans which cover the person have an order of benefit determination rule that determines its benefits first.

Secondary Plan: means a Plan which is not a Primary Plan.

GENERAL RULES:

1. The Primary Plan must pay its benefits as if the Secondary Plan did not exist. A Plan that does not a have a COB provision may not take the benefits of another Plan into account when paying benefits.
2. A Secondary Plan may take the benefits of another Plan into account when it is secondary to the other Plan.

ORDER OF BENEFIT DETERMINATION RULES: This Plan determines its order of benefits using the first of rules which follow that apply:

1. A Plan which covers a person as an Employee or Subscriber and not as a Dependent will determine its benefits before a Plan which covers that person as a Dependent.

2. **Dependent Child/Parents Not Separated or Divorced.** The Plan of the parent whose birthday (month and day) falls earlier in a year will determine its benefits before a Plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined first. If the other Plan has a "gender of parent" rule rather than a "birthday" rule and as a result the Plans do not agree on the order of benefits, the rule of the other Plan will apply.

3. **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a Dependent of divorced or separated parents, benefits for the child are determined in this order:
   a. first, the Plan of the parent with custody of the child;
   b. then, the Plan of the spouse of the parent with the custody of the child, and
   c. finally, the Plan of the parent not having custody of the child.

   If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. If the parent with financial responsibility has no coverage for the child, but that parent's spouse does, the spouse's Plan is primary. This subparagraph does not apply with respect to any Plan period during which any benefits are actually paid or provided before the entity has that actual knowledge.

   If the specific terms of a court decree state that the parents share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the order of benefit determination rules outlined in paragraph 2 (Dependent Child/Separated or Divorced Parent), will apply.

4. **Active/Inactive Employee.** A Plan which covers a person as an active Employee who is neither laid-off nor retired will determine its benefits (for Employee and dependents) before those of a plan which covers that same person as a laid-off or retired Employee. If the Plans do not agree on the order of benefits because the other Plan does not have this rule, this rule 4 will be ignored.

5. **Longer/Shorter Length of Coverage.** When none of the above rules determine an order of benefits, the Plan which has covered the person for the longer period of time will be determined first. To determine the length of time a person has been covered under a Plan, two Plans are treated as one if the person was eligible under the second within 24 hours after the first ended. The start of a new Plan does not include: a) a change in the amount or scope of a Plan's benefits; b) a change in the entity which pays, provides or administers Plan benefits; or c) a change from one type of Plan to another. The length of time a person is covered under a Plan is measured from his first date of coverage under the Plan. If that date is not available, the date he first became a member of the group will be used.

PROCEDURE FOR SECONDARY PLAN: When a Plan has been determined to be secondary, benefits may be reduced as follows:

1. when one of the plans has contracted for discounted provider fees, the secondary plan may limit payment to any co-payments and deductibles owed by the insured after payment by the primary plan; or
2. if none of the plans have contracted for discounted provider fees, the secondary plan may reduce its benefits so that total benefits paid or provided by all plans for a covered service are not more than the highest allowable expense of any of the plans for that service.
3. The Secondary Plan must calculate the amount of benefits it would normally pay in the absence of coordination and apply the payable amount to unpaid covered charges owed by the insured member after benefits have been paid by the primary plan. A Secondary Plan can use its own deductibles, coinsurance and co-pays to figure the amount it would have paid in the absence of coordination, and a Secondary Plan is not required to pay a higher amount than what they would have paid in the absence of coordination.

A Secondary Plan shall only apply its own deductibles, coinsurance and co-pays to the total allowable expenses, not to the amount left owing after payment by any primary plans.

A Secondary Plan is not required to pay for a service not covered as a benefit under its Plan.

EXCESS PROVISIONS: This Plan complies with order of benefit determination rules established by the State and is a "complying plan". As a complying plan it may coordinate its benefits with a Plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those of this Plan on the following basis:

1. If this Plan is the Primary Plan, it pays its benefits first;
2. If this Plan is the Secondary Plan, it pays its benefits first but the amount paid will be determined as if this Plan were the Secondary Plan, limited to this Plan's liability; and
3. If the Plan that does not comply does not provide the information needed for this Plan to determine its benefits within a reasonable time after requested to do so, this Plan will assume that the benefits of that Plan are identical to this Plan. This Plan will pay benefits accordingly. This Plan will adjust payments made based on such assumption whenever the information becomes available as to the actual benefits of the other Plan.

If the other Plan reduces its benefits so that the Insured receives less than he would have received had this Plan paid benefits as the Secondary Plan and that Plan paid its benefits as the Primary Plan and the Subrogation provision of this Plan applies, then this Plan will advance to or on behalf of the Insured an amount equal to the difference.

In no event will this Plan advance more than would have been paid had this Plan been the Primary Plan, less any amount previously paid under this Plan. In consideration of this advance, this Plan will be subrogated to all rights of the Insured against the other Plan.

FACILITY OF PAYMENT: A payment made under another Plan may include an amount which should have been paid under this Plan. If it does, We may pay the amount to the organization which made that payment in order to satisfy the intent of this COB provision. That amount will then be treated as though it were a benefit paid under this Plan. To the extent such payment is made, We are fully discharged from liability under this Plan. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits in the form of services.

RIGHT OF RECOVERY: If the amount of the payments made by Us is more than the amount necessary at that time to satisfy the intent of this COB provision, We may recover the excess from one or more of: a) the persons We have paid or for whom We have paid benefits; b) insurance companies; or c) other organizations. The "amount of the payments made" includes the reasonable cash value of the benefits in the form of services.

MAXIMUM BENEFITS: This Plan, whether a Primary or Secondary Plan, will never pay a greater total benefit than would have been paid had there been no other Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION: Certain facts are needed to apply COB rules. We have the right to decide what facts We need such as divorce decrees or court documents. We may release to or obtain from any insurance company or other organization or person any needed facts without the consent of any person. Each person claiming benefits under this Plan must furnish Us any facts We need to apply these COB rules.

CLAIMS INFORMATION

OUR RIGHT TO CONTEST: After the Policy has been in force for two years, we do not have the right to contest its various provisions except for non-payment of premiums. After coverage for the insured person has been in force for two years during the insured person's lifetime, we do not have the right to contest the insured person's coverage except for fraud or non-payment of premium.

PAYMENT OF CLAIMS: If the Policy provides coverage of a claimant as a Dependent of a parent who has legal responsibility for the Dependent's medical care, and such parent does not have custody of the Dependent, We may, upon request of the custodial parent, make the payments directly to the provider of care. Any payments so made will release Us from all further liability to the Insured to the extent of the payments made. Benefits for other losses are paid to the Insured. However, We have the right to pay all or part of the benefits due to the provider of care. This is true whether or not the Insured is alive. If the Insured has died and We do not pay accrued benefits to the provider of care, benefits will be paid to the Insured's estate.

The policy will pay benefits of a Dependent child to a person who is not covered under the Policy if the following conditions are met:

1. a certified copy of the court order providing for the managing or possessory conservator of the child issued by a court of competent jurisdiction in Texas or any other state is submitted to Us.
2. a written notice that the person is the managing or possessory conservator of the child is submitted to Us.

We are required to pay benefits to The Texas Department of Human Services in certain situations shown below. In these situations, this method of benefit payment replaces any description of benefit payment shown in the Policy.

All benefits paid on behalf of a Dependent child must be paid directly to The Texas Department of Human Services under the following conditions:

1. The Texas Department of Human Services is paying the benefits for the Dependent child; and
2. the Covered Person has legal custody of the Dependent child or the Covered Person does not have legal custody of the Dependent child but is required to pay child support.

A notice must be attached to our claim department form to the claim form and submit both forms to Us. Payment will be made to The Texas Department of Human Services if it has paid for any covered expenses through Medicaid.

CLAIMANT COOPERATION PROVISION: Failure of a claimant to cooperate with Us in the administration of a claim may result in the termination of a claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

PROOF OF LOSS AND FILING LIMIT: Written proof of loss must be submitted to Us if you are seeking payment or reimbursement for covered services. Claims must be submitted to Us within 365 days from date of service. Claims submitted after 365 days from date of service will be denied. Adjustments or corrections to claims are denied if submitted more than one year after the claim was processed.

TIME OF PAYMENT OF CLAIM: We will pay immediately, or within 30 days following receipt of due written proof of loss, all benefits due under the Policy. If You are not living and We have not paid the provider of care, benefits will be paid to Your estate.

YOUR RIGHT TO APPEAL: If your claim, or any portion of your claim, has been denied, you may file a written appeal with Us within 60 days after receiving the written denial. You should provide any additional information or documentation not available when the original claim was filed or reviewed by Us, as well as a statement as to why the claim should be paid.

We will, within 60 days, make a full and fair review of the decision to deny benefits and notify you in writing of the decision. Our decision is final and binding on the Plan and claimant.

LEGAL ACTIONS: We may not be sued on a health claim before 60 days after proof of loss has been given to Us. We may not be sued after 3 years (5 years in Kansas; 6 years in South Carolina) from the time proof of loss is required unless the law in the area where You live allows a longer period of time.

PHYSICAL EXAMINATION: We have the right to examine the person whose injury or sickness is the basis of claim as often as We may reasonably require during the pendency of a claim.

CONFORMITY WITH STATE LAW: If any provision of the Policy or Certificate is in conflict with the laws in the state where it is issued it is amended to conform to the minimum requirements of such laws.

FRAUD WARNING: Any person who knowingly, and with intent to defraud or deceive Us or any other person, makes a Request for Insurance or any claim for the proceeds of the Policy containing any false, incomplete or misleading information may be guilty of a crime. In New York, any person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

RIGHT OF RECOVERY

WHEN THIS PROVISION APPLIES: An insured person may incur charges due to injuries for which benefits are paid by the Policy. The injuries may be caused by the act or omission of another person. If so, the insured person may have a claim against that other person for payment of dental charges. If recovery under the claim is made, the insured person must repay Us the recovery made from: (a) the other person; or (b) the other person's insurer.

AMOUNT SUBJECT TO REFUND: Only the amount recovered for charges incurred will be subject to refund. One-third of the net recovery will be deemed to be for such charges. However, in no case will the amount of refund exceed the amount of benefits paid for the injury under the Policy.

DEFINED TERMS: "Recovery" means monies paid to the insured person through judgment, settlement or otherwise to compensate for all losses caused by the injuries. "Net Recovery" means the insured person's recovery less attorney's fees and court costs incurred in making the recovery. "Refund" means repayment to us for benefits paid.

RECOVERY FROM ANOTHER INSURER OF THE INSURED: This right of refund also applies when an insured person recovers under an uninsured or underinsured motorist plan.

ACE Group of Companies

Notice of HIPAA Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is effective as of September 23, 2013.

The ACE Group of Companies, as affiliated covered and hybrid entities, (the "Company") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information, and to inform you about:

- The Company's uses and disclosures of Protected Health Information ("PHI")
- Your privacy rights with respect to your PHI;
- The Company's duties with respect to your PHI;
- Your right to file a complaint with the Company and to the Secretary of the U.S. Department of Health and Human Services ("HHS"); and
- The person or office to contact for further information regarding the Company's privacy practices.

PHI includes all individually identifiable health information transmitted or maintained by the Company, regardless of form (e.g. oral, written, electronic).

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), regulates PHI use and disclosure by the Company. You may find these rules at *45 Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

I. Notice of PHI Uses and Disclosures

A. Required Uses and Disclosures

Upon your request, the Company is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of Health and Human Services to investigate or determine the Company's compliance with the privacy regulations.

B. Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations

The Company and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Company also may also disclose PHI to a plan sponsor for purposes related to treatment, payment and health care operations and as otherwise permitted under HIPAA to the extent the plan documents restrict the use and disclosure of PHI as required by HIPAA.

Treatment is the provision, coordination or management of health care and related services.

It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Company may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment includes, but is not limited to, actions to make coverage determinations and payment (including establishing employee contributions, claims management, obtaining payment under a contract of reinsurance, utilization review and pre-authorizations). For example, the Company may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Company.

Health care operations include, but are not limited to, underwriting, premium rating and other insurance activities relating to creating or reviewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Company may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions. The Company will not use or disclose PHI that is genetic information for underwriting purposes.

The Company also may contact you to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you.

C. Uses and Disclosures that Require Your Written Authorization

The Company will not use or disclose your PHI for the following purposes without your specific, written authorization:

- Use and disclosure of psychotherapy notes, except for your treatment, Company training programs, or to defend Company against litigation filed by you.
- Use and disclosure for marketing purposes, except for face to face communications with you.
- Use and disclosure that constitute the sale of your PHI. The Company does not sell the PHI of its customers.

Except as otherwise indicated in this notice, uses and disclosures of PHI will be made only with your written authorization subject to your right to revoke such authorization. You may revoke an authorization by submitting a written revocation to the Company at any time. If you revoke your authorization, the Company will no longer use or disclose your PHI under the authorization. However, any use or disclosure made in reliance of your authorization before its revocation will not be affected.

D. Uses and Disclosures Requiring Authorizations or Opportunity to Agree or Disagree Prior to the Use or Release

If you authorize in writing the Company to use or disclose your own PHI, the Company may proceed with such use or disclosure without meeting any other requirements and the use or disclosure shall be consistent with the authorization.

Disclosure of your PHI to family members, other relatives or your close personal friends is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

E. Uses and Disclosures for which Consent, Authorization or Opportunity to Object is Not Required

Use and disclosure of your PHI is allowed without your authorization or request under the following circumstances:

(1) When required by law.

(2) When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls and to conduct post-market surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

(3) When authorized by law to report information about abuse, neglect or domestic violence. In such case, the Company will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law where the parents or other representatives may not be given access to the minor's PHI.

(4) The Company may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(5) The Company may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Company that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

(6) When required for law enforcement purposes (for example, to report certain types of wounds).

(7) For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Company's best judgment.

(8) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(9) The Company may use or disclose PHI for government-approved research, subject to conditions.

(10) When consistent with applicable law and standards of ethical conduct if the Company, in good faith, believes the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(11) For certain government functions such as related to military service or national security.

(12) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

(13) That is "incident to" an otherwise permitted use or disclosure of PHI by the Company.

II. Rights of Individuals

A. Right to Request Restrictions on Use and Disclosure of PHI

You may request the Company to restrict its use and disclosure of your PHI to carry out treatment, payment or health care operations, or to restrict its use and disclosure to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Company may not be required to agree to your request, unless you have paid out of pocket in full for services, depending on the specific facts.

The Company will accommodate reasonable requests to receive communications of PHI by alternative means or alternative locations, such as a location other than your home. The Company will accommodate this request if you state in writing that you would be in danger from receiving communications through the normal means.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests should be made to: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

B. Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Company maintains the PHI.

"*Protected Health Information"* (PHI) includes all individually identifiable health information transmitted or maintained by the Company, regardless of form.

"*Designated Record Set*" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Company is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of Health and Human Services.

C. Right to Amend PHI

You have the right to request the Company to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Company has 60 days after the request to act on the request. A single 30-day extension is allowed if the Company is unable to comply with the deadline. If the request is denied in whole or part, the Company must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

You or your personal representative(s) will be required to complete a form to request amendment of the PHI in your designated record set.

D. Right to Receive an Accounting of PHI Uses and Disclosures

Upon your request, the Company will provide you with an accounting of disclosures by the Company of your PHI during the six (6) years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; or (4) based upon your own written authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Company will charge a reasonable, cost-based fee for each subsequent accounting.

E. Right to Obtain a Paper Copy of This Notice Upon Request (Even if you have consented to receive this notice electronically)

To obtain a paper copy of this notice contact: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

F. Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The Company retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

III. The Company's Duties

The Company is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices and to notify affected individuals of a breach of unsecured PHI. The Company is required to abide by the terms of this notice.

The Company reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Company prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all past and present participants and beneficiaries for whom the Company still maintains PHI. This notice and any revised version of this notice will be posted on the Company's internal website or mailed.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Company or other privacy practices stated in this notice.

A."Minimum Necessary" Standard

When using or disclosing PHI, or when requesting PHI from another covered entity, the Company will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of HHS;
- Uses or disclosures that are required by law; and
- Uses or disclosures that are required for the Company's compliance with legal regulations.

This notice does not apply to information that has been "de-identified." *De-identified information* is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Company may use or disclose "summary health information" to a plan sponsor for obtaining premium bids or modifying, amending or terminating the Company, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Company Sponsor has provided health benefits under the Company; and from which identifying information has been deleted in accordance with HIPAA.

IV. Your Right to File a Complaint with the Company or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Company in care of: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

The Company will not retaliate against you for filing a complaint.

V. Contact Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

VI. ACE Group of Companies Legal Entities

The ACE Group of Companies include the following: ACE American Insurance Company, ACE Property and Casualty Insurance Company, Illinois Union Insurance Company, ACE Fire Underwriters Insurance Company, Combined Insurance Company of America, Combined Life Insurance Company of New York. These companies have designated themselves as *hybrid entities* and only those designated health care components identified by such companies are subject to HIPAA. In addition, these companies are legally separate affiliated companies under common ownership and have designated themselves as a *single covered entity* for purposes of HIPAA compliance.

ACE Group of Companies

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A. Required Uses and Disclosures

Upon your request, the Company is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of Health and Human Services to investigate or determine the Company's compliance with the privacy regulations.

B. Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations

The Company and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Company also may also disclose PHI to a plan sponsor for purposes related to treatment, payment and health care operations and as otherwise permitted under HIPAA to the extent the plan documents restrict the use and disclosure of PHI as required by HIPAA.

Treatment is the provision, coordination or management of health care and related services.

It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Company may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment includes, but is not limited to, actions to make coverage determinations and payment (including establishing employee contributions, claims management, obtaining payment under a contract of reinsurance, utilization review and pre-authorizations). For example, the Company may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Company.

Health care operations include, but are not limited to, underwriting, premium rating and other insurance activities relating to creating or reviewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Company may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions. The Company will not use or disclose PHI that is genetic information for underwriting purposes.

The Company also may contact you to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you.

C. Uses and Disclosures that Require Your Written Authorization

The Company will not use or disclose your PHI for the following purposes without your specific, written authorization:

- Use and disclosure of psychotherapy notes, except for your treatment, Company training programs, or to defend Company against litigation filed by you.
- Use and disclosure for marketing purposes, except for face to face communications with you.
- Use and disclosure that constitute the sale of your PHI. The Company does not sell the PHI of its customers.

Except as otherwise indicated in this notice, uses and disclosures of PHI will be made only with your written authorization subject to your right to revoke such authorization. You may revoke an authorization by submitting a written revocation to the Company at any time. If you revoke your authorization, the Company will no longer use or disclose your PHI under the authorization. However, any use or disclosure made in reliance of your authorization before its revocation will not be affected.

D. Uses and Disclosures Requiring Authorizations or Opportunity to Agree or Disagree Prior to the Use or Release

If you authorize in writing the Company to use or disclose your own PHI, the Company may proceed with such use or disclosure without meeting any other requirements and the use or disclosure shall be consistent with the authorization.

Disclosure of your PHI to family members, other relatives or your close personal friends is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

E. Uses and Disclosures for which Consent, Authorization or Opportunity to Object is Not Required

Use and disclosure of your PHI is allowed without your authorization or request under the following circumstances:

(1) When required by law.

(2) When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls and to conduct post-market surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

(3) When authorized by law to report information about abuse, neglect or domestic violence. In such case, the Company will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law where the parents or other representatives may not be given access to the minor's PHI.

(4) The Company may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(5) The Company may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Company that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

(6) When required for law enforcement purposes (for example, to report certain types of wounds).

(7) For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Company's best judgment.

(8) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(9) The Company may use or disclose PHI for government-approved research, subject to conditions.

(10) When consistent with applicable law and standards of ethical conduct if the Company, in good faith, believes the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(11) For certain government functions such as related to military service or national security.

(12) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

(13) That is "incident to" an otherwise permitted use or disclosure of PHI by the Company.

II. Rights of Individuals

A. Right to Request Restrictions on Use and Disclosure of PHI

You may request the Company to restrict its use and disclosure of your PHI to carry out treatment, payment or health care operations, or to restrict its use and disclosure to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Company may not be required to agree to your request, unless you have paid out of pocket in full for services, depending on the specific facts.

The Company will accommodate reasonable requests to receive communications of PHI by alternative means or alternative locations, such as a location other than your home. The Company will accommodate this request if you state in writing that you would be in danger from receiving communications through the normal means.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests should be made to: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

B. Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Company maintains the PHI.

"*Protected Health Information"* (PHI) includes all individually identifiable health information transmitted or maintained by the Company, regardless of form.

"*Designated Record Set*" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Company is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of Health and Human Services.

C. Right to Amend PHI

You have the right to request the Company to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Company has 60 days after the request to act on the request. A single 30-day extension is allowed if the Company is unable to comply with the deadline. If the request is denied in whole or part, the Company must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

You or your personal representative(s) will be required to complete a form to request amendment of the PHI in your designated record set.

D. Right to Receive an Accounting of PHI Uses and Disclosures

Upon your request, the Company will provide you with an accounting of disclosures by the Company of your PHI during the six (6) years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; or (4) based upon your own written authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Company will charge a reasonable, cost-based fee for each subsequent accounting.

E. Right to Obtain a Paper Copy of This Notice Upon Request (Even if you have consented to receive this notice electronically)

To obtain a paper copy of this notice contact: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

F. Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The Company retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

III. The Company's Duties

The Company is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices and to notify affected individuals of a breach of unsecured PHI. The Company is required to abide by the terms of this notice.

The Company reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Company prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all past and present participants and beneficiaries for whom the Company still maintains PHI. This notice and any revised version of this notice will be posted on the Company's internal website or mailed.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Company or other privacy practices stated in this notice.

A."Minimum Necessary" Standard

When using or disclosing PHI, or when requesting PHI from another covered entity, the Company will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of HHS;
- Uses or disclosures that are required by law; and
- Uses or disclosures that are required for the Company's compliance with legal regulations.

This notice does not apply to information that has been "de-identified." *De-identified information* is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Company may use or disclose "summary health information" to a plan sponsor for obtaining premium bids or modifying, amending or terminating the Company, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Company Sponsor has provided health benefits under the Company; and from which identifying information has been deleted in accordance with HIPAA.

IV. Your Right to File a Complaint with the Company or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Company in care of: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

The Company will not retaliate against you for filing a complaint.

V. Contact Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact: ACE US Customer Services, 436 Walnut Street, Philadelphia, PA 19106, 1-800-352-4462.

VI. ACE Group of Companies Legal Entities

The ACE Group of Companies include the following: ACE American Insurance Company, ACE Property and Casualty Insurance Company, Illinois Union Insurance Company, ACE Fire Underwriters Insurance Company, Combined Insurance Company of America, Combined Life Insurance Company of New York. These companies have designated themselves as *hybrid entities* and only those designated health care components identified by such companies are subject to HIPAA. In addition, these companies are legally separate affiliated companies under common ownership and have designated themselves as a *single covered entity* for purposes of HIPAA compliance.

CHUBB

CHUBB GROUP
U.S. PRIVACY NOTICE

FACTS	WHAT DOES THE CHUBB GROUP DO WITH YOUR PERSONAL INFORMATION?
Why?	Insurance companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal and state law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: ▪ Social Security number and payment history ▪ insurance claim history and medical information ▪ account transactions and credit scores When you are no longer our customer, we continue to share information about you as described in this notice.
How?	All insurance companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons insurance companies can share their customers' personal information; the reasons the Chubb Group chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Chubb share?	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes – to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes – information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	We don't share
For our affiliates to market to you	No	We don't share
For nonaffiliates to market to you	No	We don't share
Questions?	**Call 1-800-258-2930 or go to** https://www2.Chubb.com/us-en/privacy.aspx	

Who is providing this notice?	The Chubb Group. A list of these companies is located at the end of this document.
What we do	
How does Chubb Group protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. We restrict access to personal information to our employees, affiliates' employees, or others who need to know that information to service the account or to conduct our normal business operations.
How does Chubb Group collect my personal information?	We collect your personal information, for example, when you ▪ apply for insurance or pay insurance premiums ▪ file an insurance claim or provide account information ▪ give us your contact information We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only ▪ sharing for affiliates' everyday business purposes – information about your creditworthiness ▪ affiliates from using your information to market to you ▪ sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. ▪ Our affiliates include those with a Chubb name and financial companies, such as Westchester Fire Insurance Company and Great Northern Insurance Company.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. ▪ Chubb does not share with nonaffiliates so they can market to you.
Joint Marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. ▪ Our joint marketing partners include categories of companies such as banks.

Other important information

For Insurance Customers in AZ, CA, CT, GA, IL, MA, ME, MN, MT, NV, NC, NJ, OH, OR, and VA only: Under state law, under certain circumstances, you have the right see the personal information about you that we have on file. To see your information, write Chubb Group Attention: Privacy Inquiries, 202 Hall's Mill Road, P.O. Box 1600, Whitehouse Station, NJ 08889-1600. Chubb may charge a reasonable fee to cover the costs of providing this information. If you think any of the information is not accurate, you may write us. We will let you know what actions we take. If you do not agree with our actions, you may send us a statement. If you want a full description of privacy rights that we will protect in accordance with the law in your home state, please contact us and we will provide it. We may disclose information to certain third parties, such as law enforcement officers, without your permission.

For Nevada residents only: We may contact our existing customers by telephone to offer additional insurance products that we believe may be of interest to you. Under state law, you have the right to opt out of these calls by adding your name to our internal do-not-call list. To opt out of these calls, or for more information about your opt out rights, please contact our customer service department. You can reach us by calling 1-800-258-2930, emailing us at privacyinquiries@Chubb.com, or writing to Chubb Group, Attention: Privacy Inquiries, 202 Hall's Mill Road, P.O. Box 1600, Whitehouse Station, NJ 08889-1600. You are being provided this notice under Nevada state law. In addition to contacting Chubb, Nevada residents can contact the Nevada Attorney General for more information about your opt out rights by calling 775-684-1100, emailing bcpinfo@ag.state.nv.us, or by writing to: Office of the Attorney General, Nevada Department of Justice, Bureau of Consumer Protection: 100 North Carson Street, Carson City, NV 89701.

For Vermont residents only: Under state law, we will not share information about your creditworthiness within our corporate family except with your authorization or consent, but we may share information about our transactions or experiences with you within our corporate family without your consent.

Chubb Group Companies Providing This Notice

This notice is being provided by the following Chubb Group companies to their customers located in the United States: ACE American Insurance Company, ACE Capital Title Reinsurance Company, ACE Fire Underwriters Insurance Company, ACE Insurance Company of the Midwest, ACE Life Insurance Company, ACE Property and Casualty Insurance Company, Agri General Insurance Company, Atlantic Employers Insurance Company, Bankers Standard Fire and Marine Company, Bankers Standard Insurance Company, Century Indemnity Company, Chubb Custom Insurance Company, Chubb Indemnity Insurance Company, Chubb Insurance Company of New Jersey, Chubb Lloyds Insurance Company of Texas, Chubb National Insurance Company, Executive Risk Indemnity Inc., Executive Risk Specialty Insurance Company, Federal Insurance Company, Great Northern Insurance Company, Illinois Union Insurance Company, Indemnity Insurance Company of North America, Insurance Company of North America, Pacific Employers Insurance Company, Pacific Indemnity Company, Penn Millers Insurance Company, Texas Pacific Indemnity Company, Vigilant Insurance Company, Westchester Fire Insurance Company and Westchester Surplus Lines Insurance Company.