YOUR GROUP VOLUNTARY DENTAL BENEFITS

UNITED OF OMAHA LIFE INSURANCE COMPANY

A Mutual *of* Omaha Company

FOR EMPLOYEES OF:

Unimex Trade & Logistics, LLC

CLASS(ES):

All Eligible Employees Electing High Plan

REVISION EFFECTIVE DATE:

September 1, 2025

PUBLICATION DATE:

August 1, 2025

Group Number: G000BY7C

NOTICE

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

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

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

www.MutualofOmaha.com/dental

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

WORKERS' COMPENSATION NOTICE

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

HAVE A COMPLAINT OR NEED HELP?

If you have a problem with a claim or your premium, call your insurance company. If you can't work out the issue, The Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. It you don't, you may lose your right to appeal.

United of Omaha Life Insurance Company
To get information or file a complaint with your insurance company:

Call: United of Omaha Life Insurance Company
Toll-free: 1-800-927-9197
Email: www.mutualofomaha.com
Mail: United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, NE 68175

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection
MC: CO-CP
Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711-2030

¿TIENE UNA QUEJA O NECESITA AYUDA?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

United of Omaha Life Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros:

Llame a: United of Omaha Life Insurance Company
Teléfono gratuito: 1-800-927-9197
Correo electrónico: www.mutualofomaha.com
Dirección postal: United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, NE 68175

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection
MC: CO-CP
Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711-2030

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

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

United of Omaha Life Insurance Company certifies that Group Policy Number GUDB-BY7C (Policy) has been issued to Unimex Trade & Logistics, LLC (the Policyholder).

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

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

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

We will notify the Policyholder in writing at least 60 days before any increase in premium rates.

This Certificate replaces any certificate of insurance previously issued under the Policy.

UNITED OF OMAHA LIFE INSURANCE COMPANY

James T. Blackledge
Chief Executive Officer

Terrance S. DeWald
Corporate Secretary

SCHEDULE

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

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

There will be no difference in Policy benefits, deductibles, or maximums between In-Network and Out-Network.

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

POLICY INFORMATION

Policyholder:	Unimex Trade & Logistics, LLC
Revised Date:	September 1, 2025
Policy Anniversary:	September 1
Policy Number:	GUDB-BY7C
Policy Year:	January 1 through December 31 of the same year
Classes:	All Eligible Employees Electing High Plan
Network:	Mutually Preferred

GENERAL PROVISIONS

Deductible

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

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

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

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

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

Percentage Payable

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

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

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

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

Policy Year Maximum Benefit

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

	In-Network	**Out-Network**
Policy Year Maximum Benefit	$1,500	$1,500

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

Rollover Benefit

Only Type A, B and C Covered Services are considered for Rollover Benefit. Covered Services with a Lifetime Maximum Benefit are not considered for Rollover Benefit.

The Policy Year Maximum Benefit will be used to calculate the Rollover Benefit.

You will be entitled to Rollover Benefits during a Policy Year if you have:

a) received at least one routine dental examination and one routine cleaning; and
b) satisfied all applicable waiting periods; and
c) used less than 50% of the Policy Year Maximum Benefit.

If the above conditions are met during a Policy Year, the Policy Year Maximum Benefit for you and your Dependent will be increased by 25% for the following Policy Year creating an Adjusted Annual Maximum Benefit. You and/or your Dependent may continue to qualify for this Rollover Benefit each Policy Year until the earned Rollover Benefit equals the Policy Year Maximum Benefit. In no event will the Adjusted Annual Maximum Benefit exceed an amount equal to two times the Policy Year Maximum Benefit.

If coverage under the Policy ends for any reason, all Rollover Benefit will be lost.

Orthodontia Lifetime Maximum Benefit

Coverage is limited to Dependent children only.

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

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

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

Work in Progress

Benefits will be provided for dentures, bridgework, and cast restorations for which the final impression is taken prior to the date an Insured Person's insurance ends if final placement of the denture, bridgework, or cast restoration occurs within 31 days after the Insured Person's insurance ends.

General Anesthesia Benefit

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

Predetermination of Benefits

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

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

COVERED SERVICES

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

Type A Covered Services	**Benefit**
Examination/Evaluations	2 services in a 12 month period.
Bitewing X-rays	4 x-rays in a 12 month period.
Full Mouth Series or Panoramic X-rays	1 service in a 36 month period.
Periapical or Occlusal X-rays	The submission of multiple x-rays on the same date of service will be benefited up to the maximum allowed for a Full Mouth Series of x-rays.
Fluoride Treatment	2 services in a 12 month period for Dependent children up to age 14.
Cleaning (Prophylaxis)	2 services in a 12 month period.
Sealants	1 service per occlusal surface of first and second permanent molars without existing fillings in 36 month period for Dependent children up to age 14.
Space Maintainers, including recementation	Benefits are payable for initial placement and any recementation for Dependent children up to age 14.
Brush Biopsy / Cancer Screen	2 services in a 12 month period.

Type B Covered Services	**Benefit**
Palliative Treatment	Benefits are payable for treatment of minor dental pain.
Periodontal Maintenance	2 services in a 12 month period in addition to routine cleanings. Benefits are payable only when this procedure follows active periodontal treatment.
Fillings	Benefits are payable for amalgam (silver) and composite/resin (white) fillings. Replacement of fillings allowed once in a 12 month period.
Stainless Steel and Other Prefabricated Crowns	Benefits are payable 1 per tooth per lifetime up to age 16.
Simple Extractions	Benefits are payable for simple extractions of erupted teeth.
Surgical Extractions	Benefits are payable for the extraction of teeth requiring a cutting procedure.
Endodontics	Benefits are payable for services such as pulpal therapy and root canal therapy. Retreatment of a root canal is payable once in a lifetime and only after 12 months have passed since the original root canal was completed.
Periodontics – Surgical	Benefits are payable for surgical treatment of gum and supporting bone disease. Services are limited to one service per area of the mouth in a 24 month period.
Periodontics – Non-Surgical	Benefits are payable for non-surgical services such as scaling and root planning. Services are limited to one service per area of the mouth in a 24 month period.
Oral surgery	Benefits are payable for oral surgery, including x-rays, pre- and post-operative care, and surgical extractions. This benefit does not include TMD surgery.
General Anesthesia or Intravenous (I.V.) Sedation	Benefits are payable when service is provided with a covered surgical procedure.

Type C Covered Services	**Benefit**
Full or Partial Removable Dentures	Benefits are payable for final dentures.
Replacement of Full or Partial Removable Dentures	Benefits are payable if the existing denture is more than 10 years old or significant structural changes occurred within the mouth due to extractions or other oral surgery.
Repair of Full or Partial Removable Dentures	Benefits are payable if the service is performed more than 6 months after initial denture placement. Benefits are payable once in any 36 month period. Benefits include the addition of teeth to a denture.
Adjustments to Full or Partial Removable Dentures	Benefits are payable if the service is performed more than 6 months since initial insertion of the denture. Payable once in 12 months thereafter.

Tissue Conditioning, Rebasing or Relining of Full or Partial Removable Dentures	Benefits are payable if the service is performed more than 6 months after any previous adjustment, tissue conditioning, rebasing or relining. Payable once in 36 months thereafter.
Bridgework	Benefits are payable for the replacement of lost, extracted, or congenitally missing teeth. Benefits are payable for Insured Persons age 16 and older.
Replacement of Bridgework	Benefits are payable if the existing bridgework is more than 10 years old or significant structural changes occurred within the mouth due to extractions or other oral surgery.
Repair and Recementation of Bridgework	Benefits are payable if the service is performed more than 6 months after initial bridge placement. Payable once in 12 months thereafter.
Cast Crowns, Inlays, Onlays, and Labial Veneers	Benefits are payable for damage due to decay or tooth fracture, but only if the tooth cannot be restored with standard filling material. Benefits are payable for Insured Persons age 16 and older.
Replacement of Cast Crowns, Inlays, Onlays, and Labial Veneers	Benefits are payable if the existing crown, inlay, onlay or veneer is more than 10 years old and cannot be repaired.
Repair and Recementation of Cast Crowns, Inlays, Onlays, and Labial Veneers	Benefits are payable if the service is performed more than 6 months after initial restoration placement. Payable once in 12 months thereafter.

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

EXCLUSIONS

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

a) not identified as a Covered Service in this Schedule;
b) considered an Experimental or Investigational Device, Treatment or Procedure;
c) not considered Medically Necessary, provided for patient convenience, or provided solely to relieve mental anxiety, unless specifically provided in the Schedule;
d) when benefits are payable under any other group health or dental plan maintained or sponsored by the Policyholder;
e) related to tests and laboratory exams, bacteriologic studies, caries susceptibility tests, pulp vitality tests, oral pathology laboratory, oral hygiene instruction, education or training, histopathologic examinations, diagnostic casts and photographs, magnetic resonance imaging and gnathological procedures, services, supplies or procedures related to orthognathic surgery, osteoplasties, osteotomies, LeFort procedures, maxillofacial prosthetics, vestibuloplasties, stomatoplasties, and any procedures related to the diagnosis or treatment of jaw fractures;
f) related to the diagnosis or treatment of Temporomandibular Disorders (TMD) and functional/myofunctional therapy except to the extent as may be required by state law, or unless specifically provided in the Schedule;
g) related to Cosmetic or Reconstructive Procedures;
h) related to restorations, devices, appliances or dentures to change vertical dimension, to alter occlusion or to replace tooth structure lost through attrition, erosion or abrasion including occlusal adjustment or equilibration;
i) related to the replacement of lost dentures or the replacement of lost or broken appliances;
j) related to athletic mouth guards, bruxism appliances or any procedure related to such appliance, except as specifically provided in the Schedule as an orthodontic procedure;
k) related to precision attachments, connector bars, coping materials, overdentures, unilateral partial dentures and stress breakers;
l) related to drugs and medications whether or not they require a written prescription, or for analgesics or euphoric drugs, except as specifically provided in the Schedule;
m) related to cast restorations, full or partial dentures and fixed bridgework when the final impressions were taken before the date insurance began or after insurance ends;
n) customarily performed in association with a more comprehensive dental procedure, including local anesthesia, pulp capping (direct or indirect), insulating/cementing bases, periodontal splinting (permanent or provisional), temporary

crowns, bridges, and dentures; or any minor associated gingival involvement when performed in conjunction with a cast restoration or fixed bridgework;

o) related to any endodontic, periodontic, crown, bridge abutment or appliance performed on teeth with a guarded, questionable or poor prognosis;
p) related to duplication of treatments, procedures or supplies, including when an Insured Person transfers from the care of one Provider to the care of another Provider;
q) that arise out of or in the course of employment for any employer or that Insured Person is paid benefits under any workers' compensation or occupational disease law, or receives any settlement from a worker's compensation carrier;
r) when the Insured Person is not liable for payment;
s) provided or paid for by a state or federal government or its agencies;
t) resulting from an intentionally self-inflicted injury;
u) resulting from the Insured Person's voluntary participation in a riot or in the commission of a felony;
v) resulting from an act of declared or undeclared war or armed aggression;
w) incurred while the Insured Person is on active duty or training in the Armed Forces, National Guard, Reserves or an auxiliary unit of any state or country or which any governmental body or its agencies are liable;
x) associated with the evaluation, preparation, maintenance, placement or removal of implants or for any implant related prosthetic, including but not limited to crowns, bridges and dentures.

ELIGIBILITY

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

WHEN YOU BECOME ELIGIBLE FOR INSURANCE (ELIGIBILITY WAITING PERIOD)

If you complete the 60 day Eligibility Waiting Period on or before the Policy Effective Date, you become eligible for insurance on the Policy Effective Date.

If you are not eligible for insurance on the Policy Effective Date, or you are hired after the Policy Effective Date, you become eligible for insurance on the day after you complete the 60 day Eligibility Waiting Period.

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

WHEN A DEPENDENT BECOMES ELIGIBLE FOR INSURANCE

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

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

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

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

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

WHEN INSURANCE BEGINS FOR YOU

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

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

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

WHEN INSURANCE BEGINS FOR YOUR DEPENDENT

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

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

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

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

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

FIRST ENROLLMENT PERIOD

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

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

SUBSEQUENT ENROLLMENT PERIOD

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

WHEN ELECTION CHANGES ARE PERMITTED

Life Events

If you experience a Life Event, you may submit a Written Request to add or change insurance within 31 days of the Life Event. If the Written Request is submitted more than 31 days after the date of a Life Event, you may not add or change insurance until a Subsequent Enrollment Period is offered.

REINSTATEMENT OF INSURANCE

You may be eligible to reinstate insurance that has ended in accordance with this provision. For any insurance requiring an election, you must submit a Written Request to reinstate insurance within 31 days of your return to Active Work. A standard enrollment form may be used for this request. If the Written Request is submitted more than 31 days after the date you return to Active Work, you may not re-enroll for insurance until a Subsequent Enrollment Period is offered. If insurance is reinstated for you, insurance may also be reinstated for any eligible Dependents.

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

Non-Payment of Premium or Voluntary Termination of Insurance

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

Involuntary Reduction in Hours

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

Rehired Due to Layoff or Termination

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

Rehired Due to Leave of Absence

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

WHEN INSURANCE ENDS

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

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

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

GRACE PERIOD

There is a grace period of 31 days for payment of premium. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 31-day grace period that follows. We consider premium to be paid on the date we receive it.

Insurance will stay in force during the grace period as long as premium is paid before the end of the grace period. Coverage will end on the cancellation date specified in such notice, as long as the full premium has been paid up to that date.

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

EXCEPTIONS TO WHEN INSURANCE ENDS

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

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

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

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

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

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

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

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

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

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

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

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

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

COBRA CONTINUATION

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

For You and Your Dependents

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

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

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

During the period you continue coverage:

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

For Your Dependents Only

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

a) you die;
b) you become entitled to Medicare benefits;
c) you and your Spouse are legally separated;
d) your marriage is ended by divorce; or
e) a child is no longer an eligible Dependent.

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

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

Notice Requirements

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

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

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

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

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

Payment of Premium

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

End of Continuation

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

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

Other Continuation Provisions

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

OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE

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

a) the Policyholder may pay the premiums; or

b) you may pay premium to the Policyholder who will then submit premium to us.

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

Payment of premium does not guarantee eligibility for coverage.

CLAIM PROVISIONS

CLAIM FORMS

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

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

You may use a standard claim form supplied by your Provider or you may find a form on our website: **www.MutualofOmaha.com/dental**, or call customer service at 1-800-927-9197.

NOTICE OF CLAIM

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

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

HOW TO OBTAIN PLAN BENEFITS

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

CLAIM ASSISTANCE

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

PAYMENT OF CLAIMS

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

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

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

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

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

CLAIM REVIEW AND APPEAL PROCESS

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

Claim Review
We will notify you in writing of our decision to either approve or deny a claim within 48 days of the date it is received by us. If we deny your claim in whole or in part, we will explain the reasons for our denial in our notice. If you disagree with the reasons given, you or your authorized representative may ask that we reconsider your claim through the appeal process.

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

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

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

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

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

REFUND TO US

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

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

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

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

INDEPENDENT EXAMINATION

We may require an Insured Person to be examined by a Dentist as we direct to assist in determining whether benefits are payable. You may not impose any conditions on an examination such as pre-approval of the examiner, attendance of a third party or audio/video recording of the examination.

We will pay for these examinations; however, you may be responsible for fees associated with failure to notify the examination office of your appointment cancellation within the required amount of time specified by the examiner. We may recover this fee by reducing benefits that are payable. We will not require more than a reasonable number of such examinations.

STANDARD PROVISIONS

ENTIRE INSURANCE CONTRACT

The insurance contract consists of:

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

CHANGES IN THE INSURANCE CONTRACT

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

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

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

DELEGATION

We may delegate some of our obligations and responsibilities under the Policy, such as claims administration, network management and other administrative services, to a third party designated by us.

LEGAL ACTIONS

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

CONFORMITY WITH STATE AND FEDERAL LAW

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

COORDINATION OF BENEFITS (COB)

If the Claimant is covered by another Plan or Plans, the benefits under this Policy and the other Plans will be coordinated.

As required by the State of Texas, the following words and terms, when used in this Coordination of Benefits section, have the following meanings, unless the context clearly indicates otherwise.

Allowable Expense — Except as otherwise provided in § 3.3505 of this title (relating to Allowable Expenses), or where a statute requires a different definition, any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.

Allowed Amount — the amount of a billed charge that a carrier determines to be covered for services provided by an Out-Network health care provider or physician. The allowed amount includes the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

Birthday — refers only to the month and day in a calendar year and does not include the year in which the individual is born.

Carrier — an entity authorized under the Insurance Code to provide coverage subject to this subchapter, including an insurer, health maintenance organization, group hospital service corporation, or stipulated premium company.

Certificate holder — an insured or enrollee who is covered other than as a dependent under a group plan or a group-type plan.

Claim — a request that benefits be provided or paid. The benefits claimed may be in the form of:

a) services, including supplies;
b) payment for all or a portion of the expenses incurred;
c) a combination of subparagraphs (A) and (B) of this paragraph; or
d) an indemnification.

Closed Panel Plan — A plan that provides health benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes benefits for services provided by other health care providers or physicians, except in cases of emergency or referral by a panel member.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) — Coverage provided under a right of continuation under federal law.

Contract — Refers to an insurance policy, insurance certificate, or health maintenance organization evidence of coverage.

Coordination of Benefits (COB) — A provision establishing an order in which plans pay their claims and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Custodial Parent:

a) the parent with the right to designate the primary residence of a child by a court order under the Family Code or other applicable law; or
b) in the absence of a court order, the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

Group-Type Contract — a contract that is not available to the public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage.

High-Deductible Health Plan — a high-deductible health plan under § 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and Insurance Code Chapter 1653.

Hospital Indemnity Benefits — benefits not related to expenses incurred. This term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Plan — a form of coverage with which coordination is allowed. For purposes of this subchapter:

a) plan includes:
    1. any contract to which this subchapter applies;
    2. limited benefit policies under § 3.3079 of this title (relating to Minimum Standards for Limited Benefit Coverage), excluding Disability Income Protection Coverage under § 3.3075 of this title (relating to Minimum Standards for Disability Income Protection Coverage);
    3. uninsured arrangements of group or group-type coverage;
    4. the medical benefits coverage in automobile insurance contracts;
    5. Medicare or other governmental benefits; as permitted by law; and
    6. group insurance contracts, individual insurance contracts, and subscriber contracts that pay or reimburse for the cost of dental care.
b) plan does not include:
    1. the Texas Health Insurance Pool as described in Insurance Code Chapter 1506;
    2. workers' compensation insurance coverage;
    3. hospital confinement indemnity coverage or other fixed indemnity;
    4. specified disease coverage;
    5. supplemental benefit coverage under § 3.3080 of this title (relating to Supplemental Coverage) and as described in Insurance Code Chapter 1203;
    6. accident-only coverage;
    7. specified accident coverage;
    8. school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour basis" or on a "to and from school" basis;
    9. benefits provided in long-term care insurance contracts for nonmedical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
    10. Medicare supplement policies;
    11. a state plan under Medicaid;
    12. a governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; or
    13. an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Policyholder — the primary insured named in an individual health insurance policy or evidence of coverage.

Primary Plan — a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

a) the plan either has no order of benefit determination rules, or its rules differ from those permitted by this subchapter; or
b) all plans that cover the person use the order of benefit determination rules required by this subchapter, and under those rules, the plan determines its benefits first.

Secondary Plan —a plan that is not a primary plan.

COVERAGE BY TWO OR MORE PLANS

When a person is covered by two or more plans, the rules for determining the order of benefit payments will be determined as provided in paragraphs 1–5 of this subsection.

1. The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.
2. A plan may take into consideration the benefits paid or provided by another plan only when, under this subchapter, it is secondary to that other plan.
3. If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses an Out-Network dental provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.
4. When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.
5. If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans' benefits are determined in relation to each other.

Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan, that, under the rules of this subchapter, has its benefits determined before those of that secondary plan.

Exception

Except as provided by *Coverage by Membership in a Group* of this section and § 3.3509(b) of this title (relating to Miscellaneous Provisions), a plan that does not contain order of benefit determination provisions that are consistent with this subchapter is always the primary plan unless the provisions of both plans state that the complying plan is primary.

Coverage by Membership in a Group

Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage must be excess to any other parts of the plan provided by the contract holder.

ORDER OF BENEFIT DETERMINATION

Each plan determines its order of benefits using the first of the following rules that apply.

Nondependent or dependent

The plan that covers the person other than as a Dependent, for example, as an employee, subscriber, policyholder, certificate holder, or retiree, is the primary plan, and the plan that covers the person as a Dependent is the secondary plan.

If the person is a Medicare beneficiary and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

1. secondary to the plan covering the person as a Dependent; and
2. primary to the plan covering the person as other than a Dependent, for example, a retired employee.

Under *If a person is a Medicare beneficiary*, as applicable, the order of benefits is reversed so that the plan covering the person as an employee, subscriber, policyholder, certificate holder, or retiree is the secondary plan and the other plan covering the person as a Dependent is the primary plan.

DEPENDENT CHILD COVERED UNDER MORE THAN ONE PLAN

Unless there is a court order stating otherwise, plans covering a Dependent child must determine the order of benefits using the following rules that apply.

For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

1. the plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
2. if both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

For a Dependent child whose parents are divorced or are not living together, whether or not they have ever been married:

1. if a court order states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the Dependent child's health care expenses, and that parent's spouse does, then the spouse's plan is the primary plan. This clause must not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court order provision.
2. if a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions under *For a Dependent child whose parents are married or are living together, whether or not they have ever been married* must determine the order of benefits.
3. if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions under *For a Dependent child whose parents are married or are living together, whether or not they have ever been married* must determine the order of benefits.
4. if there is no court order allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child is as follows:
   a) the plan covering the custodial parent;
   b) the plan covering the custodial parent's spouse;

c) the plan covering the noncustodial parent; then
d) the plan covering the noncustodial parent's spouse.

For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits must be determined, as applicable, as if the individuals were parents of the child.

For a Dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, the below *Length of Time* section applies.

In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule to the Dependent child's parents and the Dependent's spouse.

ACTIVE EMPLOYEE, RETIRED, OR LAID-OFF EMPLOYEE

The plan that covers a person as an active employee who is neither laid-off nor retired, or as a dependent of an active employee, is the primary plan. The plan that covers that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

If the plan that covers the same person as a retired or laid-off employee or as a Dependent of a retired or laid-off employee does not conform to the above requirements, and as a result, the plans do not agree on the order of benefits, this paragraph does not apply. This paragraph does not apply if paragraph (1) of this subsection can determine the order of benefits.

COBRA OR STATE CONTINUATION COVERAGE

If a person whose coverage is provided under COBRA or under a right of continuation under state or other federal law is covered under another plan, the plan covering the person as an employee, subscriber, or retiree or covering the person as a Dependent of an employee, subscriber, or retiree is the primary plan, and the plan covering that same person under COBRA or under a right of continuation under state or other federal law is the secondary plan.

If the plan that covers the same person under COBRA or under a right of continuation does not conform to the requirements stated above, and as a result, the plans do not agree on the order of benefits, this paragraph does not apply. This paragraph does not apply if paragraph (1) of this subsection can determine the order of benefits.

Length of Time

If the *Order of Benefit Determination* does not determine the order of benefits, the plan that has covered the person for the longer period of time is the primary plan. The plan that has covered the person for the shorter period of time is the secondary plan.

1. To determine the length of time a person has been covered under a plan, two successive plans must be treated as one if the covered person was eligible under the second plan within 24 hours after the first plan ended.
2. 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 that pays, provides, or administers the plan's benefits; or
   c) a change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.
3. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

Sharing Equally Between the Plans

If this Coordination of Benefits section does not determine the order of benefits, the Covered Expenses must be shared equally between the plans.

REQUEST TO COLLECT AND RELEASE NEEDED INFORMATION

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

PLAN REIMBURSEMENT FOR THIRD PARTY PAYMENT

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

RIGHT OF RECOVERY

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

DEFINITIONS

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

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

Actively Working, *Active Work* means you are:

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

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

Adjusted Annual Maximum Benefit means an amount equal to the sum of:

a) the amount of the Policy Year Maximum Benefit; plus
b) the amount of Rollover Benefits which have been added to the Policy Year Maximum Benefit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dental Hygienist or Denturist means a person who is:

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

Dentist means a person who is:

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

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

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

A dependent does not include:

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

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

Employee means a person who is:

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

An employee does not include a person:

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

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

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

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

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

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

If a Dependent child is Incapacitated and reaches an age where they are no longer considered eligible, they may continue to be insured as long as they remain Incapacitated. Proof of incapacity will be required within 31 days of a Dependent child reaching the limiting age. Proof of continued incapacity may be required by us, but not more frequently than once a year.

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

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

Life Event means:

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

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

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

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

a) provided for the prevention, diagnosis, or direct treatment of a dental injury, condition or disease;
b) appropriate and consistent with the symptoms and findings or diagnosis and treatment of the Insured Person's dental injury, condition or disease; and
c) provided in accordance with generally accepted professional standards of dental practice.

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

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

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

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

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

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

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

Policyholder means Unimex Trade & Logistics, LLC.

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

Policy Anniversary means September 1 of each Policy Year.

Policy Effective Date means September 1, 2021.

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

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

Prior Plan means any similar insurance policy:

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

Provider means a Dentist, Denturist, or Dental Hygienist.

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

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

Spouse means the person to whom you are legally married. Spouse also includes your domestic partner, civil union partner, reciprocal beneficiary, or equivalent, as recognized and allowed by law in your jurisdiction of residence.

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

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

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

Group Voluntary Dental Benefits

Unimex Trade & Logistics, LLC

Group Number: G000BY7C

United of Omaha Life Insurance Company

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