# MUSE HEATING & AIR CONDITIONING

# Master Policy and Certificate

*for your*

**Dental Expense Benefits**

UnitedHealthcare®
A UnitedHealth Group Company

# UNITEDHEALTHCARE INSURANCE COMPANY

# DENTAL INSURANCE

# GROUP POLICY

# FOR

# MUSE HEATING & AIR CONDITIONING

GROUP NUMBER: GA5S1928IM
EFFECTIVE DATE: July 1, 2013
DENTAL PLAN: P3337

Offered and Underwritten by
UnitedHealthcare Insurance Company

# Group Policy

# UnitedHealthcare Insurance Company

185 Asylum Street
Hartford, CT 06103-3408

1-800-445-9090

This Group Policy ("Policy") is entered into by and between UnitedHealthcare Insurance Company ("Company"), and the "Enrolling Group," as described in Exhibit 1.

Upon receipt of the Enrolling Group's application and payment of the required Policy Charges, this Policy is deemed executed. The Company agrees with the Enrolling Group to provide Coverage for Dental Services set forth herein, subject to the terms, conditions, exclusions, and limitations of this Policy. The Enrolling Group's application is made a part of this Policy.

This Policy replaces and supersedes any previous agreements relating to the Coverage of Dental Services between the Enrolling Group and the Company. The terms and conditions of this Policy will in turn be superseded by those of any subsequent agreements relating to the Coverage of Dental Services between the Enrolling Group and the Company.

The Company will not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. The Company will not be responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's benefit plan.

This Policy will become effective at 12:01 a.m. at the Enrolling Group's address on the date specified in Exhibit 1, and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of this Policy as provided herein. When the Policy is terminated, as provided for in Article 5, this Policy and all Coverage under this Policy will end at 12:00 midnight on the date of termination.

This Policy is delivered in and governed by the laws of the State of MISSISSIPPI.

Issued By:

UnitedHealthcare Insurance Company

President

# Article 1: Definitions

The terms used in this Policy have the same meaning given those terms in the *Certific ate of Coverage ("Certificate"),* unless otherwise specifically defined in this Policy.

# Article 2: Dental Services

Subscribers and their Enrolled Dependents are entitled to Coverage for Dental Services subject to the terms, conditions, limitations and exclusions set forth in the *Certificate(s)* and *Schedule(s ) of Covered Dental Services,* included in this Policy. The *Certificate(s)* and *Schedule(s) of Covered Dental Services* describe the Covered Dental Services including any optional Riders and Amendments, required Copayments, and the terms, conditions, limitations and exclusions related to Coverage.

# Article 3: Premium Rates and Policy Charge

## 3.1 Premiums

Monthly Premiums payable by or on behalf of Covered Persons are specified on Exhibit 2 to the Policy entitled "Premiums".

The Company reserves the right to change the schedule of rates for Premiums as described in Exhibit 1.

## 3.2 Computation of Policy Charge

Each Policy Charge will be calculated based on the number of Subscribers in each Coverage classification the Company shows in its records at the time of calculation, at the Premiums then in effect. The Policy Charge is calculated as described in Exhibit 1.

## 3.3 Adjustments to the Policy Charge

Retroactive adjustments may be made for any additions or terminations of Subscribers or changes in Coverage classification not reflected in the Company's records at the time the Policy Charge is calculated by the Company. However, no retroactive credit will be granted for any change occurring more than 60 days prior to the date the Company received notification of the change from the Enrolling Group, nor will retroactive credit be granted for any calendar month in which a Subscriber has received Dental Services.

The Enrolling Group will notify the Company in writing within 30 days of the effective date of enrollments, terminations or other changes; provided, however, that the Enrolling Group will notify the Company in writing each month of any changes in the Coverage classification of any Subscriber.

In the event there is any increase in premium tax, guarantee or uninsured fund assessment or other governmental charges relating to or calculated in regard to Premium such increase will be automatically added to the Premium.

## 3.4 Payment of the Policy Charge

The Policy Charge is payable in advance by the Enrolling Group to the Company as described in Exhibit 1. The first Policy Charge is due and payable on the effective date of the Policy. Subsequent Policy Charges are due and payable no later than the first day of each period thereafter that the Policy is in effect.

A late payment charge will be assessed for any Policy Charge not received by the due date. A service charge will be assessed for any non-sufficient-fund check received in payment of the Policy Charge. All Policy Charge payments will be accompanied by supporting documentation which states the names of the Covered Persons for whom payment is made.

The Enrolling Group will reimburse the Company for attorney's fees and any other costs related to collecting delinquent Policy Charges.

### 3.5 Grace Period

A Grace Period of 31 days will be granted for the payment of any Policy Charge, during which time the Policy will continue in force. In no event will the Grace Period extend beyond the date the Policy terminates.

This Policy will automatically terminate retroactive to the last paid date of Coverage if the Grace Period expires and any Policy Charge remains unpaid, or if the Company receives written notice of termination from the Enrolling Group during the Grace Period.

# Article 4: Enrollment and Eligibility

### 4.1 Initial Eligibility Period

Eligible Persons and their Dependents may enroll for Coverage under the Policy during the Initial Eligibility Period. The Initial Eligibility Period is the period of time agreed to by the Enrolling Group and the Company.

### 4.2 Open Enrollment

If specified in the *Certificate(s)* , the Enrolling Group will provide an Open Enrollment Period as specified in the *Certificate(s),* during which Eligible Persons may enroll for Coverage under the Policy.

### 4.3 Eligibility Conditions

The eligibility conditions stated in the application are in addition to those specified in Section 2 of the *Certificate(s).*

### 4.4 Effective Date of Coverage

Coverage for properly enrolled Eligible Persons and their Dependents will begin on the date stated in Exhibit 1.

# Article 5: Policy Termination

### 5.1 Conditions for Termination of This Entire Policy

This Policy and all Coverage under this Policy will automatically terminate on the earliest of the dates specified below:

A. At the Company's option, retroactive to the last paid date of Coverage, if the Grace Period expires and any Policy Charge remains unpaid.

B. On the date specified by the Enrolling Group, after at least 31 days prior written notice to the Company that this Policy will be terminated.

C. On the date specified by the Company, in written notice to the Enrolling Group that this Policy will be terminated, due to the Enrolling Group's violation of participation and contribution rules.

D. On the date specified by the Company in written notice to the Enrolling Group that this Policy will be terminated because the Enrolling Group provided the Company with false information material to the execution of this Policy or to the provision of Coverage under this Policy. The Company has the right to rescind this Policy back to the effective date.

E. On the date specified by the Company, after at least 90 days prior written notice to the Enrolling Group that this Policy will be terminated because the Company will no longer renew or issue this type of dental benefit plan within the applicable market.

F. On the date specified by the Company, after at least 180 days prior written notice to the applicable state authority and to the Enrolling Group that this Policy will be terminated because the Company will no longer renew or issue any employer dental benefit plan within the applicable market.

### 5.2 Payment and Reimbursement Upon Termination

Upon any termination of this Policy, the Enrolling Group will be and will remain liable to the Company for the payment of any and all Premiums which are unpaid at the time of termination, including a pro rata fee for any period this Policy was in force during the Grace Period, if any, preceding the termination.

# Article 6: General Provisions

## 6.1 Entire Policy

The Policy, including the *Certificate(s), Schedule(s) of Covered Dental Services,* the application of the Enrolling Group, any individual Subscriber applications, Amendments and Riders will constitute the entire Policy between parties. All statements made by the Enrolling Group or by a Subscriber will, in the absence of fraud, be deemed representations and not warranties.

## 6.2 Time Limit on Certain Defenses

No statement made by the Enrolling Group, except a fraudulent statement, will be used to void this Policy after it has been in force for a period of 2 years.

## 6.3 Amendments and Alterations

Amendments to the Policy are effective upon 31 days written notice to the Enrolling Group. Riders are effective on the date specified by the Company. No change will be made to this Policy unless made by an Amendment or a Rider which is signed by an executive officer of the Company. No agent has authority to change this Policy or to waive any of its provisions.

## 6.4 Relationship Between Parties

The relationships between the Company and providers and relationships between the Company and Enrolling Groups, are solely contractual relationships between independent contractors. Providers and Enrolling Groups are not agents or employees of the Company, nor is the Company or any employee of the Company an agent or employee of providers or Enrolling Groups.

The relationship between a provider and any Covered Person is that of provider and patient. The provider is solely responsible for the services provided by it to any Covered Person. The relationship between any Enrolling Group and any Covered Person is that of employer and employee, Dependent, or other Coverage classification as defined in this Policy. The Enrolling Group is solely responsible for enrollment and Coverage classification changes (including termination of a Covered Person's Coverage through the Company) and for the timely payment of the Policy Charge.

## 6.5 Records

The Enrolling Group will furnish the Company with all information and proofs which the Company may reasonably require with regard to any matters pertaining to this Policy. The Company may at any reasonable time inspect all documents furnished to the Enrolling Group by an individual in connection with the Coverage, and the Enrolling Group's payroll, and any other records pertinent to the Coverage under this Policy.

By accepting Benefits under this Policy, each Covered Person authorizes and directs any person or institution that has provided services to them, to furnish the Company or it's designees any and all information and records or copies of records relating to the services provided to the Covered Person. The Company has the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

The Company agrees that such information and records will be considered confidential. The Company has the right to release any and all records concerning dental services which are necessary to implement and administer the terms of this Policy, for appropriate medical review or quality assessment, or as the Company is required by law or regulation.

During and after the term of the Policy, the Company and its related entities may use and transfer the information gathered under the Policy for research and analytic purposes.

## 6.6 Administrative Services

The services necessary to administer this Policy and the Coverage provided under it will be provided in accordance with the Company's or its designee's standard administrative procedures. If the Enrolling Group requests that such administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Enrolling Group will pay for such services or reports at the Company's or its designee's then-current charges for such services or reports.

## 6.7 ERISA

When this Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C., 1001 et seq., the Company will not be named as and will not be the Plan Administrator or the named fiduciary of the welfare plan, as those terms are used in ERISA.

## 6.8 Examination of Covered Persons

In the event of a question or dispute concerning Coverage for Dental Services, the Company may reasonably require that a Covered Person be examined at the Company's expense by a Dentist acceptable to the Company.

## 6.9 Clerical Error

Clerical error will not deprive any individual of Coverage under this Policy or create a right to benefits. Failure to report the termination of Coverage will not continue such Coverage beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Premiums will be made. However, no such adjustment in Premiums or Coverage will be granted by the Company to the Enrolling Group for more than 60 days of Coverage prior to the date the Company received notification of such clerical error.

## 6.10 Workers' Compensation Not Affected

The Coverage provided under this Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

## 6.11 Conformity with Statutes

Any provision of this Policy which, on its effective date, is in conflict with the requirements of applicable state or federal statutes or regulations is hereby amended to conform to the minimum requirements of such statutes and regulations.

## 6.12 Waiver/Estoppel

Nothing in the Policy, *Certificate(s)* or *Schedule(s) of Covered Dental Services* is considered to be waived by any party unless the party claiming the waiver receives the waiver in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of the Policy, *Certificate(s)* or *Schedule(s) of Covered Dental Services,* or to exercise any option which is herein provided, will in no way be construed to be a waiver of such provision of the Policy, *Certificate(s)* or *Schedule(s) of Covered Dental Services.*

## 6.13 Headings

The headings, titles and any table of contents contained in the Policy, *Certificate(s)* or *Schedule(s) of Covered Dental Services* are for reference purposes only and will not in any way affect the meaning or interpretation of the Policy, *Certificate(s)* or *Schedule(s) of Covered Dental Services.*

## 6.14 Unenforceable Provisions

If any provision of the Policy, *Certificate(s)* or *Schedule(s) of Covered Dental Services* is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions will remain in effect and the illegal or unenforceable provision will be modified so as to conform to the original intent of the Policy, *Certificate(s)* or *Schedule(s) of Covered Dental Services* to the greatest extent legally permissible.

## 6.15 Notice

Written notice given by the Company to an authorized representative of the Enrolling Group is deemed notice to all affected Subscribers and their Enrolled Dependents in the administration of this Policy, including termination of this Policy. The Enrolling Group is responsible for giving notice to Covered Persons.

Any notice sent to the Company under this Policy and any notice sent to the Enrolling Group will be addressed as described in Exhibit 1.

## 6.16 Continuation Coverage

The Company agrees to provide Coverage under the Policy for those Covered Persons who are eligible to continue Coverage under federal or state law, as described in the *Certificate(s).*

The Company will not provide any administrative duties with respect to the Enrolling Group's compliance with federal or state law. All duties of the plan sponsor or plan administrator, including but not limited to notification of COBRA and state law continuation rights, and billing and collection of Premium, remain the sole responsibility of the Enrolling Group.

## 6.17 Subscriber's Individual Certificate(s)

The Company will issue *Certificate(s), Schedule(s) of Covered Dental Services* and any attachments to the Enrolling Group for delivery to each covered Subscriber. The *Certificate(s), Schedule(s) of Covered Dental Services* and any attachments will show all the benefits and provisions of the Policy.

# Exhibit 1 to Dental Group Policy

1. **Parties.** The parties to this Policy are UnitedHealthcare Insurance Company ("Company") and MUSE HEATING & AIR CONDITIONING ("Enrolling Group").

2. **Effective Date.** The effective date of this Policy is July 1, 2013 .

3. **Premiums.** The Company reserves the right to change the schedule of rates for Premiums, after 30 days prior written notice on the first anniversary of the Effective Date of the Policy specified in the application or on any monthly due date thereafter, or on any date the provisions of the Policy are amended. The Company also reserves the right to change the schedule of rates for Premiums, retroactive to the Effective Date, if a material misrepresentation has resulted in a lower schedule of rates.

4. **Computation of Policy Charge.**

   A pro rata Premium, calculated on the number of days Covered Persons are actually Covered under this Policy, will be charged for Covered Persons whose effective date of Coverage falls on a date other than the first of the month or for Covered Persons whose Coverage is terminated on a date other than the first of the month.

5. **Payment of the Policy Charge.** The Policy Charge is payable in advance by the Enrolling Group to the Company on a monthly basis.

6. **Minimum Participation Requirement.** The minimum participation requirement is 2 Eligible Persons enrolled for Coverage under the Policy.

7. **Notice.**

   Any notice sent to the Company under this Policy will be addressed to:

   UnitedHealthcare Insurance Company
   185 Asylum Street
   Hartford, CT 06103-3408

   Any notice sent to Enrolling Group under this Policy will be addressed to:

   MUSE HEATING & AIR CONDITIONING
   1610 DANCY BLVD
   STE A
   HORN LAKE, MS 386370000
   GA5S1928IM Enrolling Group Number

# Exhibit 2 to Dental Group Policy

## Premiums

Monthly Premiums payable by or on behalf of Covered Persons are specified in the Cost Summary.

# Exhibit 3 to Dental Group Policy

## Policy Contents

All of the Dental Services and provisions in the *Certificate(s), Schedule(s) of Covered Dental Services,* Amendments and Riders, issued for the Enrolling Group are included and made part of this Policy.

# Summary of Mississippi Life and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

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

## Disclaimer

The Guaranty Association may not provide coverage for this policy. If coverage is provided, it will be subject to substantial limitations and exclusions, and require continued residency in this state. You should not rely on coverage by the Guaranty Association when selecting an insurer. Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract. Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales, solicitation or inducement to purchase any form of insurance. You may contact either the Guaranty Association or the Mississippi Insurance Department at the following addresses if you should have any questions regarding this notice.

**Mississippi Life and Health Insurance Guaranty Association**

300 North Mart Plaza, Suite 2

Jackson, MS 39206

**Mississippi Insurance Department**

1804 Walter Sillers Building

Jackson, MS 39205

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

## Coverage

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

## Exclusions from Coverage

However, persons holding such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a hospital or medical service organization, whether profit or nonprofit, a health maintenance organization (HMO), a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or other person that operates on an assessment basis, an insurance exchange, or any similar entity.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy or contract of reinsurance, unless assumption certificates were issued pursuant to the reinsurance policy or contract;
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits or payment of any fees or allowances to any person in connection with the service to or administration of the policy or contract;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts issued to or in connection with benefit plans protected under federal Pension Benefit Guaranty Corporation ("PBGC") regardless of whether the PBGC has yet become liable to make any payments with respect to the benefit plan;
- Portions of any unallocated annuity contract not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association with respect to the policy or contract are preempted by State or Federal law;
- Obligations that do not arise under the express written terms of the policy or contract, including claims based on marketing materials, side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements, or claims for policy misrepresentations, or extra-contractual or penalty or consequential or incidental damages claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

## Limits on Amount of Coverage

The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, with respect to any one life, regardless of the number of policies or contracts, the maximum obligation of the Guaranty Association is $300,000 in benefits except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance in which case the aggregate liability of the Guaranty Association is $500,000. Within these overall limits, the Guaranty Association will not pay more than $300,000 in life insurance death benefits, $100,000 in net cash surrender and net cash withdrawal values, $300,000 for disability insurance benefits, $500,000 for basic hospital medical and surgical insurance or major medical insurance benefits, $100,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $5,000,000 limit with respect to any contract owner for unallocated annuity benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or to the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.