

PacifiCare®
A UnitedHealthcare Company



GROUP INSURANCE CERTIFICATE
Egyptian Area Schools Employee Benefit Trust

GROUP INSURANCE CERTIFICATE

POLICYHOLDER: EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST
POLICY NUMBER: D1000
POLICY EFFECTIVE DATE: January 1, 2006
FIRST POLICY ANNIVERSARY: January 1, 2007
SUBSEQUENT POLICY ANNIVERSARIES: January 1st of each calendar year
GOVERNING JURISDICTION: Illinois

United HealthCare Insurance Company (UHC) agrees to insure the Policyholder as provided in the group policy.

By paying the first premium and accepting delivery of the group policy the Policyholder agrees to be bound by the terms of the group policy.

The group policy shall take effect as of the Policy Effective Date provided that:(a) it has been signed by an officer of UHC; (b) the Policyholder has signed the attached application; and (c) the Policyholder has paid in full the first premium for all of the insurance in force under the group policy.

The following statements are required by Illinois law:

“WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your plan’s fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or any other method, as defined by the policy.

YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill you for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll-free telephone number on your identification card.”

By:

UNITED HEALTHCARE INSURANCE COMPANY

President

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COVERAGE PROVISIONS

Second person pronouns are used in these provisions to address the insured employees. Where they appear, the terms "you" and "your" refer only to an insured employee.

SCHEDULE OF BENEFITS

The group policy uses certain terms that have special meanings. These terms are defined in definitions sections and other parts of the text.

PLANS OF DENTAL INSURANCE

Dental Insurance for covered persons under this policy shall be in accordance with the Plan of insurance elected by the employee. Each employee may elect the Low Option Plan or the High Option Plan. For an employee who elects the dependents insurance, the Plan of insurance elected by the employee will be in force for both the employee and his dependents.

PREFERRED PROVIDERS

You may visit any dentist at any time with no difference in benefits. However, it is to your advantage to select a dentist who is a dental preferred provider. If you select a dentist who is a dental preferred provider, the amount of out-of-pocket expense to you may be substantially lower. Call the number shown on your dental insurance identification card for a list of dental preferred providers in your area.

For a description of how the covered charge limits are determined for dental preferred providers and dental nonpreferred providers, see the Covered Charge Limits provision of the Dental Insurance section. For a definition of dental preferred provider and dental non-preferred provider, see the Dental Definitions provision of the Dental Insurance section.

DENTAL INSURANCE: LOW OPTION PLAN

DENTAL DEDUCTIBLE	\$50
FAMILY DEDUCTIBLE MAXIMUM.....	\$150 of covered dental charges applied by covered persons in your family toward their Dental Deductibles

DENTAL PERCENTAGE PAYABLE

The percentages are applied to the covered dental charges after any applicable deductible amount has been met.

Preventive Services	80%
Basic Services	70%

CALENDAR YEAR MAXIMUM	\$750
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COVERED CHARGE LIMITS. The limits are shown in the Covered Charge Limits and Dental Services List provisions of the Dental Insurance.

MAJOR DENTAL SERVICES NOT COVERED. This plan does not pay benefits for any Major Dental Services. See the Dental Exclusions.

PREDETERMINATION OF BENEFITS. The Claims Administrator, per agreement with Us, suggests that a predetermination of benefits take place when a dentist estimates that the charges for a program of treatment will be more than \$400.

DENTAL INSURANCE: HIGH OPTION PLAN

DENTAL DEDUCTIBLE	\$50
The Dental Deductible does not apply to charges incurred for Preventive Dental Services.	
FAMILY DEDUCTIBLE MAXIMUM.....	\$150 of covered dental charges applied by covered persons in your family toward their Dental Deductibles

DENTAL PERCENTAGE PAYABLE

The percentages are applied to the covered dental charges after any applicable deductible amount has been met.

Preventive Services	100%
Basic Services	80%
Major Services	
Year of Dental Coverage	
1st Year	0%
2nd Year	50%
3rd Year & Years Thereafter	50%

CALENDAR YEAR MAXIMUM

Year of Dental Coverage	
1st Year	\$750
2nd Year	\$1,000
3rd Year & Years Thereafter	\$1,500

For Covered Persons Who Became Insured under the Group Policy on January 1, 2007. For a covered person who becomes insured under the group policy on the Policy Effective Date, the Dental Percentage Payable will be the percentage payable shown for 3rd Year & Years Thereafter, and the Calendar Year Maximum will be the maximum shown for 3rd Year & Years Thereafter.

All new enrollees will comply with the Progressive Percentage Payable and Calendar Year Maximums, except as specified below.

Exception for Covered Persons Who Enter the Plan after January 1, 2007, and Who Can Provide Proof of Prior Dental Coverage. For a covered person who becomes eligible for coverage after the Policy Effective Date, who becomes insured for the High Option Plan of the Dental Coverage within 31 days of first becoming eligible, and who can provide proof of prior creditable dental coverage, benefits will be payable for covered dental charges incurred by that covered person at the same benefit levels as for covered persons in the second year of coverage. On the January 1 next following such covered person's effective date of dental coverage, benefits will be payable for covered dental charges incurred by that covered person at the same benefit levels as for covered persons in the third year of coverage.

Prior creditable dental coverage is group dental coverage that was in force within the 62-day period immediately preceding the covered person's effective date of coverage under this plan.

Covered Charge Limits. The limits are shown in the Covered Charge Limits and Dental Services List provisions of the Dental Insurance.

Predetermination Of Benefits

The Claims Administrator, per agreement with Us, suggests that a predetermination of benefits take place when a dentist estimates that the charges for a program of treatment will be more than \$400.

DEPENDENT CHILD ORTHODONTIA INSURANCE (IN FORCE ONLY WHEN THE HIGH OPTION PLAN OF DENTAL INSURANCE HAS BEEN ELECTED)

NO DEDUCTIBLE. The Orthodontia Insurance is not subject to a deductible.

ORTHODONTIA PERCENTAGE PAYABLE	50%
ORTHODONTIA MAXIMUMS	
Lifetime Maximum	\$1,000
Calendar Year Maximum	\$500

Predetermination Of Benefits

A predetermination of benefits must take place before any orthodontic treatment is received.

Deferred Orthodontia Coverage

A deferment period applies to coverage for orthodontia charges. See the Deferred Orthodontia Coverage provision for an explanation of the deferment period.

A COORDINATION OF BENEFITS PROVISION IS INCLUDED. SEE THE COORDINATION OF BENEFITS SECTION FOR AN EXPLANATION OF HOW IT WORKS.

No Vested Right To Benefits

The Claims Administrator, per agreement with Us, will not pay a benefit for charges incurred for services or supplies furnished to a person following termination of that person's insurance under the group policy. Benefits will not be paid

in excess of any maximums stated in the group policy during the entire period of the person's coverage under the group policy, whether or not the period of coverage is interrupted. Benefits may be modified by Us with the agreement of the Policyholder while the group policy is in force. If benefits are modified, the revised benefits (including any reduction in or elimination of benefits) apply to charges incurred for services or supplies on or after the effective date of the modification, except as may be specified in the group policy. There is no vested right to receive the benefits of the group policy.

Exception: If a covered person ceases to be covered for insurance under the group policy, a continuation, extension, or conversion of benefits may be available as provided by the group policy or required by law.

General Definitions

Terms that are used only within one section of the group policy are defined in that section. Masculine pronouns, where they are used, shall apply to both sexes.

Accident. The term "accident" means an event that: (a) caused a physical injury; (b) was not expected and could not have been reasonably foreseen; and (c) could not have been avoided.

Benefit Maximum. A "benefit maximum" is a maximum amount of benefits that will be paid by The Claims Administrator, per agreement with Us, under the group policy for a specified type of covered charges incurred during a given period of time. The charges to which a benefit maximum applies are not considered covered charges after the benefit maximum has been reached.

Calendar Month and Calendar Year. A "calendar month" is one of the 12 named months of a calendar year. A "calendar year" is a period that starts on January 1 and ends on December 31 of each year.

Claims Administrator. "Claims Administrator" is Meritain Health, Inc., located at 300 Corporate Parkway, Amherst, New York, 14226.

Contracted Charge. A "contracted charge" is the amount of money We have agreed to pay a provider for a covered service and the provider has agreed to accept as payment in full.

Contributory, Non-contributory, and Voluntary Insurance. "Contributory insurance" is that for which you pay part of the cost. "Non-contributory insurance" is that for which you do not pay any part of the cost. "Voluntary insurance" is that for which you pay all of the cost.

Covered Employer. The term "Covered Employer" means an employer that: (a) has entered into an agreement to provide insurance for its employees under the Egyptian Area Schools Employee Benefit Trust; and (b) conforms to the administrative procedures and eligibility rules which are established by Us and the Claims Administrator.

Covered Person. The term "covered person" means an eligible employee, an eligible retired employee, or a dependent that is insured under the group policy.

Deductible. A "deductible" is an amount of covered charges that must be incurred by a covered person before the Claims Administrator, per agreement with Us, will pay benefits. No benefits will be paid for the charges applied toward a deductible.

Employees Insurance and Dependents Insurance. The terms "employees insurance" and "dependents insurance" refer to the insurance provided under the group policy for: (a) eligible employees and eligible retired employees; and (b) dependents; respectively.

Group Policy. The "group policy" is the policy of group insurance issued to the Policyholder by Us under the Policy Number shown in the Policy Specifications section.

Insurance Class. The term "insurance class" means a category of employees who are eligible for the same insurance benefits under the group policy. An insurance class must be established by the Policyholder and approved by Us.

Percentage Payable. A "percentage payable" is a factor by which an amount of covered charges is multiplied to calculate a benefit under the group policy.

Physician. The term "physician" means only a person who is licensed and practices within the scope of the license as a doctor of medicine (M.D.) or as a doctor of osteopathy (D.O.).

Placement for Adoption. The term "placement for adoption" means the date the adoptive parent assumes and retains a legal obligation for total or partial support in anticipation of the adoption.

Policyholder. The "Policyholder" is the Egyptian Area Schools Employee Benefit Trust.

Professionally Recognized Standards. The term "professionally recognized standards" means professionally recognized standards of quality, as determined by Us. To determine such standards, We may use such groups as: the American Dental Association; its affiliates and successors; peer review groups; professional review groups; and similar groups.

Qualified Medical Child Support Order. The term "qualified medical child support order" means any court or administrative judgment, decree or order issued to provide health benefit coverage for a dependent child of an employee and which meets specified criteria as determined by Us. The judgment, decree or order must be issued: (1) by a court of competent jurisdiction, or (2) through an administrative process that has the force and effect of law in the state.

Usual Charge and Customary Charge.

1. With respect to any one service or supply, "usual charge" means the fee that is regularly charged and accepted as payment in full by the provider of the service or supply.
2. With respect to any one service or supply, "customary charge" means a fee level which is in the range of fees, determined by the Claims Administrator, per agreement with Us, customarily charged for the service or supply in the geographic area concerned.

We, Us, Our. The terms "We, Us, Our" means United HealthCare Insurance Company.

EMPLOYEES ELIGIBILITY

Becoming Insured

Only a person who meets the definition of an eligible employee or an eligible retired employee may become insured for the employees insurance under the group policy. The words "you" and "your" refer only to an employee or retired employee. To become insured you must:

1. qualify as an eligible employee or an eligible retired employee;
2. enroll for the employees insurance through the Policyholder; and
3. reach an eligibility date.

For voluntary insurance, if you were previously insured for the employees insurance under the group policy and you chose to end that insurance while still eligible for it, you are not eligible to re-enroll for the employees insurance.

Eligible Employee. An "eligible employee" is a person who is working full-time for a covered employer as a regular employee. A partner or proprietor who is actively engaged in the conduct of the business of a covered employer is deemed to be an eligible employee.

Eligible Retired Employee. An "eligible retired employee" is a person who meets all of the following tests:

1. He has retired from active employment for a covered employer;
2. Immediately prior to retirement, was considered an eligible employee;
3. He is receiving or is eligible to receive pension benefits or a disability pension from either the Illinois Municipal Retirement Fund (IMRF) or the Teachers Retirement System (TRS), as determined by IMRF or TRS; and
4. The day before his retirement, he was insured under this group policy or under the Policyholder's prior group benefit plan.

Full-time Work. The terms "working full-time," "work on a full-time basis," and all other references to full-time work mean that the employee is actively engaged in the business of a covered employer for at least 20 hours per week.

Regular Employee. A "regular employee" is a person who is scheduled to work full-time for at least five months per year.

Extent of Your Employees Insurance

When you become insured you will be covered for all of the employees insurance benefits that apply to your insurance class.

Contributions

You may be required to pay all or part of the cost of the employees insurance.

Your Effective Date of Insurance

Your effective date of insurance is the date determined from the Enrollment Rules that follow. It is based on when you enroll for the employees insurance: before, on, or after your eligibility date. You may not enroll for the employees insurance more than 31 days after your eligibility date, except as specified in the Annual Enrollment Provision below.

Eligibility Date. Your eligibility date is the Policy Effective Date if you are an eligible employee or an eligible retired employee on that date. If you are an eligible employee or an eligible retired employee on the Policy Effective Date but you declined coverage under the prior carrier's plan, you must enroll in accordance with any late enrollment provision of the Enrollment Rules section below. If you become an eligible employee after the Policy Effective Date, your eligibility date is the first day of the calendar month coinciding with or next following the date you complete the Eligibility Waiting Period.

The Policy Effective Date is shown in the Policy Specifications section.

Eligibility Waiting Period. Your covered employer chooses from one of the following options:

1. none;
2. one month of employment as an eligible employee;
3. two months of employment as an eligible employee;
4. three months of employment as an eligible employee; or
5. six months of employment as an eligible employee.

Enrollment Rules

Early Enrollment. If you enroll on or before your eligibility date, your effective date is the later of the date the required premiums have been paid for your employees insurance and your eligibility date.

Timely Enrollment. If you enroll during the 31-day period that follows your eligibility date, your effective date is the later of the date the required premiums have been paid for your employees insurance and the first day of the calendar month coinciding with or next following the date the application is received by the Claims Administrator.

No Late Enrollment. You may not enroll more than 31 days after your eligibility date, except as specified in the Annual Enrollment Provision shown below.

Benefit Changes

Benefit changes will take effect on the applicable date shown below:

1. A change that results because you change insurance class will take effect on the first day of the calendar month coinciding with or next following the date you qualify for the new class.
2. A change that results from an amendment to the group policy will take effect on the date stated in the amendment.

Termination of Your Insurance

Your employees insurance will end on the earliest date shown below:

1. The last day of the calendar month in which you cease to qualify as an eligible employee or an eligible retired employee. For this insurance, the Claims Administrator, per agreement with Us, deems the employee-employer relationship to end on the date the employee stops full-time active work for a covered employer.
2. The date your employer is no longer a covered employer.
3. The last day for which the Policyholder has paid premiums for your employees insurance.
4. The date the group policy terminates.

Reinstatement

If your employees insurance ends because your full-time work for a covered employer ends, the Eligibility Waiting Period will be waived if you again become an eligible employee within 12 months of the date that your full-time work ended.

Annual Enrollment Provision

If at any time you choose not to enroll for this coverage, you may enroll later only during an Annual Enrollment Period. Your insurance will then be effective on the later of the date the required premiums have been paid for your employees insurance and the first day of the calendar month following the Annual Enrollment Period. The Annual Enrollment Period is one month of each year designated by the Policyholder as the enrollment period.

Dependents Eligibility

Insuring Dependents

Only a person who meets the definition of dependent may become insured for dependents insurance under the group policy. To become insured the person must:

1. qualify as a dependent;
2. be enrolled for the dependents insurance through the Policyholder; and
3. reach an eligibility date.

You must enroll all your dependents in order to insure any dependents. You may not enroll your dependents for any insurance benefits for which you have not enrolled as an employee.

For voluntary insurance, if a person was previously insured for dependents insurance under the group policy and you chose to end that insurance while the person was still eligible for it, that person is not eligible to be re-enrolled for the dependents insurance.

Dependent. The term "dependent" means only: (a) your wife or husband; and (b) your unmarried child who is of an age within the Age Limits for Dependent Children shown below, and who chiefly depends on you for support and is claimed as a dependent by you for purposes of filing a federal income tax return, or is named in a Qualified Medical Child Support Order. The word "child" includes your stepchild, foster child, and any other child who lives with you in a regular parent-child relationship. A child shall be deemed, for this insurance, to be a dependent of not more than one person.

The term "dependent" does not include a person who is: (a) an eligible employee or an eligible retired employee; or (b) on active duty in any armed forces.

Age Limits for Dependent Children

For Dependent Child Orthodontia Insurance: under 19 years.

For Other Dependents Insurance: under 19 years, except that a dependent child who is a full-time student and is under 25 years of age may be covered for the dependents insurance other than the Dependent Orthodontia Insurance.

A "full-time student" is a dependent child who attends, on a full-time basis, a high school, college, university, technical school, trade school, vocational school, or a home school that has an organized and verifiable curriculum.

Exception to Age Limits: If a dependent child, when he reaches the age limit shown above:

1. is insured under the group policy;
2. chiefly depends on you for support and maintenance; and
3. is continuously unable to get self-sustaining work due to a physical or mental handicap.

The child will continue to qualify as a dependent for all of the dependents insurance until the earlier of the following dates: (a) the date he recovers from the handicap; and (b) the date he no longer chiefly depends on you for support and maintenance.

Extent of Dependents Insurance

When your dependents become insured they will be covered for all of the dependents insurance benefits that apply to your insurance class.

Contributions

You may be required to pay all or part of the cost of the dependents insurance.

Your Dependents' Effective Dates of Insurance

The effective date of insurance for your dependents is determined from the Enrollment Rules that follow. It is based on when you enroll the dependents for the dependents insurance: before, on, or after the dependents' eligibility dates. You may not enroll a dependent more than 31 days after his eligibility date, except as specified in the Enrollment Rules and Annual Enrollment for Dependents provisions below.

Eligibility Date. A dependent's eligibility date is the Policy Effective Date if the dependent is an eligible dependent on that date and if the dependent was covered under the prior carrier's plan immediately prior to that date. If the dependent is an eligible dependent on the Policy Effective Date but you did not elect to cover such dependent under the prior carrier's plan, you must enroll the dependent in accordance with any late enrollment provision of the Enrollment Rules section below. For a dependent that becomes eligible after the Policy Effective Date, the eligibility date is the later of: (a) your eligibility date; or (b) the date the person qualifies as your dependent. The Policy Effective Date is shown in the Policy Specifications section.

With respect to a child named in a Qualified Medical Child Support Order (QMCSO), the date the person qualifies as your dependent means the date specified in the court or administrative judgment, decree, or order. With respect to an adopted child, the date the person qualifies as your dependent means the date of adoption or placement for adoption.

Enrollment Rules

Early Enrollment. If you enroll a dependent on or before his eligibility date, his effective date is the later of: (a) your effective date of insurance; (b) the date the required premiums have been paid for your dependents insurance; and (c) the dependent's eligibility date.

Timely Enrollment. If you enroll a dependent within the 31-day period that follows his eligibility date, his effective date is the later of: (a) your effective date of insurance; (b) the date the required premiums have been paid for your dependents insurance; and (c) the first day of the calendar month coinciding with or next following the date the application was received by the Claims Administrator. If you enroll a dependent child before his second birthday or within the 31-day period that follows his second birthday, such dependent will be considered a timely applicant for Dental Insurance and Dependent Child Orthodontia Insurance, and his effective date will be the first day of the calendar month coinciding with or next following the date the application was received by the Claims Administrator.

No Late Enrollment. You may not enroll a dependent more than 31 days after his eligibility date, except as specified above in Timely Enrollment, or as specified in the Annual Enrollment for Dependents provision below.

Exception for Future Dependents. The effective date of insurance for a dependent you acquire while you are insured for dependents insurance will be:

1. the date determined from the Enrollment Rules if you then have only one dependent insured under the group policy; or
2. the date you acquire the dependent if you then have two or more dependents insured under the group policy.

Termination of a Dependent's Insurance

A dependent's insurance will end on the earliest date shown below:

1. The last day for which the Policyholder has paid premiums for your dependents insurance.
2. The date on which the person no longer qualifies as a dependent.
3. The date your employer is no longer a covered employer.
4. The date your employees insurance ends.

Annual Enrollment for Dependents

If you have elected not to enroll a dependent for dependents insurance, you may enroll your dependent later only during an Annual Enrollment Period. If you enroll a dependent during this period, his dependents insurance will become effective on the later of the date the required premiums have been paid for your dependents insurance and the first day of the calendar month following the Annual Enrollment Period.

The Annual Enrollment Period is one month of each year designated by the Policyholder as the enrollment period.

Continuation of Dental Insurance for Spouse/Former Spouse and Dependents

Continuation of dental insurance is available to your spouse or former spouse and any insured dependents in the event of dissolution of your marriage, your death, or your retirement.

Within 30 days of your divorce, death or retirement, the spouse who wants to continue coverage must give written notice to your Covered Employer and the Claims Administrator. Your Covered Employer must notify the Claims Administrator within 15 days from receipt of notice and also send a copy of the notice to your spouse or former spouse at your spouse's or former spouse's place of residence.

We must provide, by certified mail, return receipt requested, notification to your spouse or former spouse that the Policy may be continued and the notice shall include:

1. a form for election to continue the insurance coverage;
2. the premium amount and method and place of payment;
3. instructions for returning the election form by certified mail, return receipt requested, within 30 days after the date the notice was mailed by the Claims Administrator.

Failure of your spouse or former spouse to exercise the election to continue insurance coverage by notifying the Claims Administrator by certified mail, return receipt requested, within 30 days shall terminate the right to continuation under the Policy.

If We fail to notify your spouse or former spouse of the rights to continuation, all premiums shall be waived from the date the notice was required until the date the notice is sent. Benefits will continue during this period unless coverage is terminated for all employees of your Covered Employer or former Covered Employer.

For Spouse/Former Spouse Under Age 55

Premium will be based on the following:

1. an amount, if any that would be charged to an Eligible Employee if the spouse or former spouse were a current Eligible Employee of the Covered Employer, plus;
2. an amount, if any, that the Covered Employer would contribute toward the premium if the spouse or former spouse were a current Eligible Employee of the Covered Employer.

Failure to pay the initial premium within 30 days after the notice is received terminates the continuation of benefits and the right to continuation benefits under the Policy.

Coverage terminates when the first of the following events occurs:

1. the failure to pay premiums when due, including any grace period allowed by the Policy; or

2. when coverage would terminate under the terms of the existing Policy if you and your former spouse were still married to each other; however, the existing coverage shall not be modified or terminated during the first 120 consecutive days following your death or the date of divorce, unless the Policy in existence at the time is modified or terminated as to all Eligible Employees of your Covered Employer; or
3. the date the former spouse first becomes an insured employee under any other group dental plan; or
4. the date on which the former spouse remarries; or
5. the expiration of two years from the date coverage began under this continuation provision.

Upon termination of coverage under this provision, the former spouse shall be entitled to convert to a converted policy as stated under the Dental Insurance Conversion Privilege for Spouse/Former Spouse and Dependents section of the Certificate.

For Spouse/Former Spouse Over Age 55

Premium will be based on the following:

1. an amount, if any, that would be charged an Eligible Employee if the retired Eligible Employee's spouse or former spouse were a current Eligible Employee of the Covered Employer, plus;
2. an amount, if any, that the Covered Employer would contribute toward this premium if the retired Eligible Employee's spouse or former spouse were a current Eligible Employee.

Beginning two years after coverage begins, the premium would be computed the same as above with the exception of charging an additional amount, not to exceed 20% of the total amount above, for costs of administration.

Failure to pay the initial premium within 30 days after the notice is received terminates the continuation of benefits and the right to continuation benefits under the Policy.

The right granted to retired Eligible Employees' spouses and former spouses who have attained the age of 55 at the time coverage begins under this provision shall terminate when the first of the following events occurs:

1. the failure to pay premiums when due, including any grace period allowed by the Policy; or
2. when coverage would terminate, except due to the your retirement, under the terms of the existing Policy if you and your former spouse were still married to each other; however, the existing coverage shall not be modified or terminated during the first 120 consecutive days following your death or retirement or the date of divorce, unless the Policy in existence at the time is modified or terminated as to all Eligible Employees; or
3. the date the retired Eligible Employee's spouse or former spouse first becomes an insured Eligible Employee under any other group dental plan; or
4. the date on which the former spouse remarries; or
5. the date the person reaches the qualifying age or otherwise establishes eligibility under Medicare.

Upon termination of coverage under this provision, the former spouse shall be entitled to convert to an individual policy as stated under the Dental Insurance Conversion Privilege for Spouse/Former Spouse and Dependents section of the Certificate.

A new insurer must offer continuation to the retired Eligible Employee's spouse and to an Eligible Employee's former spouse under the same terms and conditions contained in this provision if the following apply:

1. the Policy is cancelled;
2. another insurance company contracts to provide group dental insurance to the Covered Employer;
3. continuation coverage is in effect for the retired Eligible Employee's spouse or former spouse at the time of cancellation;
4. the Eligible Employee is or would have been included under the new group policy.

No person who obtains coverage under this provision shall be required to pay a rate greater than that applicable to any employee covered under the group with the exception of the additional amount, not to exceed 20% of the calculated premium beginning two years after conversion begins, for costs of administration.

Dental Insurance Conversion Privilege for Spouse/Former Spouse and Dependents

For purposes of this Conversion provision, You or Your is defined as the Eligible Employee's spouse or former spouse.

If Your continuation described above has expired, You and any insured dependents have the right to apply for an individual conversion plan.

You cannot convert if You become eligible for dental insurance under another group policy within 31 days from the date insurance under this Policy ends.

We may not allow You to convert if We determine You have other coverage similar to the conversion plan, which together results in overinsurance. We use Our own standards for overinsurance to determine this.

The conversion plan will continue to apply any waiting period of this Policy, as if insurance under this Policy were still in force.

Any benefits that are optional to the group dental insurance plan from which You are converting will not be included in the individual conversion plan.

HOW TO APPLY

You must apply to the Claims Administrator for the conversion plan within 31 days from the date the continuation insurance ends under the Policy. We do not require evidence of insurability. The plan is effective on the day immediately following the date the continuation insurance ends.

The plan will be issued on the type of form then being issued by Us for conversion. Premium must be paid with the application. Premiums are based on the type of coverage and Your age on the date You convert.

GENERAL HEALTH LIMITATIONS

Duplicate Benefits Exclusion

Benefits will not be paid more than once under the group policy for any charge.

Excluded Charges List

Section A. No benefit will be paid for or in connection with any injury or disease:

1. that is intentionally self-inflicted while sane or that is self-inflicted while insane;
2. that results from or arises out of any past or present employment or occupation for compensation or profit;
3. that results from or arises out of: (a) any military conflict or act of war, whether declared or undeclared; (b) diseases contracted or injuries sustained while in the military service of any country; (c) the covered person's taking part as a principal or accessory in illegal activities or in an illegal occupation; (d) the covered person's taking part in a riot or civil disturbance; or (e) nontherapeutic release of nuclear energy.

Section B. No benefit will be paid for or in connection with any:

1. charge, or part of a charge, that the covered person is not obligated to pay or for which the covered person would not have been billed except for the fact that the covered person was insured;
2. service that is rendered: (a) by a person who ordinarily lives in the covered person's home; or (b) by a spouse, child, parent, or sibling of the covered person or of the covered person's spouse;
3. experimental treatment;
4. service or supply provided by a hospital that is owned or run by the United States government;
5. service or supply provided, distributed through or by, directly or indirectly, or in connection with: (a) the covered person's employer; (b) the employer of any immediate family member (such as mother, father, daughter, son, sister, brother); (c) the employer of any in-laws of the same relationship; or (d) any affiliate of the covered person's employer. "Affiliate" means an entity having a parent-subsidiary or common parent relationship with such employer, or a person, entity, trustee or other representative or designee of any person or persons or entity, which either controls, or as a practical matter participates in the control of, both the person or entity in question and the covered person's employer. Participation in practical control regardless of percentage of stock ownership shall be determinative.

Dental Insurance: Low Option Plan

The Claims Administrator, per agreement with Us, will pay a Dental Benefit as determined below for the covered dental charges a covered person incurs while insured for the Dental Insurance.

Dental Benefits And Covered Charges

Benefit

A "Dental Benefit" is the amount, if any, that will be paid for covered dental charges incurred by a covered person.

The amount of a Dental Benefit is the amount the Claims Administrator, per agreement with Us, calculates in the steps shown below:

1. The charges for which a claim is submitted to the Claims Administrator are tested against the Covered Dental Charge definition. Those that meet all of the tests are the covered dental charges.
2. Any deductible amount that applies to the charges and that has not yet been met is subtracted from the amount of covered dental charges.
3. The amount of covered dental charges that remain is then multiplied by the applicable dental percentage payable.
4. If any part of the amount calculated exceeds an applicable benefit maximum, then that part is subtracted and the remainder is the amount of the Dental Benefit.

Dental Deductible

The Dental Deductible shown in the Schedule of Benefits:

1. applies to all covered dental charges unless the Schedule of Benefits states otherwise;
2. applies separately to each covered person during each calendar year; and
3. must be accumulated during the calendar year.

Only those charges to which a deductible applies can be used to satisfy that deductible.

Family Deductible Maximum. If the Family Deductible Maximum shown in the Schedule of Benefits is satisfied in any one calendar year by covered persons in your family, then the Dental Deductible will not be applied to any other charges incurred in that calendar year by covered persons in your family. As used here, "family" means you and all of your dependents that are insured for the Dental Insurance.

Dental Percentage Payable

Each percentage payable and the charges to which it applies are shown in the Schedule of Benefits. A percentage payable:

1. is applied after any applicable deductible amount has been met; and
2. applies separately to each covered person.

Dental Benefit Maximum

The Claims Administrator, per agreement with Us, will not pay more than the Calendar Year Maximum shown in the Schedule of Benefits for all covered dental charges incurred by a covered person during any one calendar year.

Covered Dental Charges

A "covered dental charge" is a charge that meets all of the tests listed below:

1. It is made by a dentist or dental hygienist for a covered dental service that is furnished to a covered person.
2. It is incurred by a covered person while the covered person is insured for the Dental Insurance. A charge is deemed to be incurred at the time the service is rendered for which the charge is made. The date a dental service is deemed to be rendered is shown in the Date Dental Service Rendered provision below.
3. It is not excluded by the Dental Exclusions, or the General Health Limitations.
4. It is for a service that: (a) is essential for the necessary care of the patient's teeth and supporting tissue; (b) is performed by a dentist or dental hygienist; (c) has a reasonably favorable prognosis; (d) is generally accepted professional practice and meets professionally recognized standards; and (e) is the least expensive procedure that will produce a result that meets professionally recognized standards. It does not exceed the smallest of the covered charge limits that apply to the service for which the charge is made. The part of a charge that does not exceed the smallest of the covered charge limits shall be considered a covered dental charge if it meets all of the tests in this provision.

Emergency Palliative Treatment Benefit

Charges made for emergency palliative treatment are covered dental charges, regardless of whether the charges are made by a dental preferred provider or a dental non-preferred provider. The term "emergency palliative treatment" means dental services provided after the sudden onset of a dental condition manifesting itself by the acute symptom of severe pain.

Covered Charge Limits

The "covered charge limits" that apply to each dental service are the lesser of the billed charge and: (a) the usual charge for the service; (b) the customary charge for the service; (c) any limit specified in the Dental Services List; (d) for dental charges made by a dental preferred provider, the contracted charge for the service.

Predetermination of Benefits

The Claims Administrator, per agreement with Us, suggests that a predetermination of benefits take place when a dentist estimates that the charges for a program of treatment will be more than \$400. As used here, "predetermination of benefits" means that before a covered person receives any such treatment, he: (a) submits to the Claims Administrator a treatment plan made out by the attending dentist; and (b) gets the Claims Administrator's estimate of the Dental Benefits for the program of treatment. This provision shall not apply to charges for emergency treatment.

Date Dental Service Rendered

For the purpose of determining Dental Benefits, a covered dental service shall be deemed to be rendered on the date shown below that applies to the service. A temporary dental service will be deemed an integral part of the final dental service rather than a separate dental service.

Dental Service Date Deemed Rendered

Root Canal Therapy The date the pulp chamber is opened and canals explored to the apex.
Periodontal Surgery The date the surgery is actually performed.
All Other Services The date the service is performed.

Benefits After Termination of Insurance

The only Dental Benefits that will be paid on behalf of a covered person after the covered person's Dental Insurance ends shall be for covered dental charges incurred for treatment that: (a) is rendered while the covered person is insured for the Dental Insurance; and (b) is completed within 30 days of the date the covered person's Dental Insurance ends.

Dental Proof

The written proof required by Us and the Claims Administrator shall include the following items:

- 1. A complete dental chart that shows extractions, missing teeth, fillings, prostheses, periodontal pocket depths, orthodontic relationships, and the date of any previous treatment.
- 2. An itemized bill for all dental care.
- 3. X-rays and study models.
- 4. Laboratory and hospital reports.

Dental Exclusions

No Dental Benefit will be paid for any charge excluded by the General Health Limitations or for any of the items listed below:

- 1. Procedure that is not necessary or that does not meet professionally recognized standards.
- 2. Procedure relating to: (a) the change of vertical dimension; (b) restoration of occlusion; (c) bite registration; or (d) bite analysis.
- 3. Procedure that is performed mainly to improve the appearance of the covered person. To correct abrasion, erosion, attrition, bruxism, abfraction; or teeth that are not periodontally sound or which have a questionable prognosis as determined by us.
- 4. That is considered cosmetic dentistry including, but not limited to porcelain on a crown, abutment or pontics on molar teeth; composite restorations on molar teeth. Services done to alter the shape or size of teeth or congenital malformations.
- 5. Replacement of an item that has been lost or stolen.
- 6. Charges made by a dentist's office for a broken or missed appointment, duplicate X-rays, sterilization of equipment, or for the filing of a claim.
- 7. Orthodontia treatment, or replacement of orthodontic retainers.
- 8. The following items and services: (a) an athletic mouthguard; (b) a specialized appliance; (c) a precision or semiprecision attachment; (d) a denture duplication; (e) oral hygiene instruction; (f) treatment for fractures; (g) myofunctional therapy; (h) orthognathic surgery, sleep disorder appliance, treatment splints.
- 9. Charge: (a) for a procedure for which any benefit is provided under a medical or orthodontia expense plan that is supplied by the Policyholder; or (b) that is used to satisfy a deductible under any such plan.
- 10. Treatment of TMJ disorders, including jaw joint problems or physical therapy.
- 11. Local anesthesia, behavior management, conscious sedation.
- 12. Initial placement of full or partial dentures, bridges or crowns to replace functional natural teeth that are:
 - a. Congenitally missing; or
 - b. Lost before insurance under this Plan is in effect except as noted below.

We will pay for initial placement of full or partial dentures or bridges to replace loss of functional natural teeth, but only if lost;

- a. While insured by the Policy; or
- b. For a dependent child whose teeth were extracted before age 17; and
- c. If the child was insured by this plan at the time of the extraction; and
- d. After any applicable waiting period for major dental services is met.

This benefit includes necessary adjustments, relines or rebases during the first six months following the date of placement.

13. Replacement within 5 years of the last placement for full and partial dentures, bridges, inlays, onlays, crown, veneers or implants.

This exclusion does not apply if the replacement is necessary because of;

- a. Extraction of a functioning natural tooth; and if the replacement is completed within 12 months of the date of the injury or extraction.
- b. An injury to sound natural teeth (other than a chewing injury) sustained in an accident.

14. Crowns, bridges, inlays, onlays, veneers or partial dentures that;

- a. Is for a tooth that can be restored by other means;
- b. Is for the purpose of periodontal splinting;
- c. Is for a tooth that does not demonstrate extensive decay or fracture.

Additional Dental Exclusions -- Major Dental Services

Covered dental charges do not include charges incurred for Major Dental Services. No Dental Benefits will be paid for any of the following dental services:

1. Crowns.
2. Crown build-ups.
3. Inlays and onlays.
4. Labial veneers.
5. Occlusal adjustment.
6. Posts and cores.
7. Implants.
8. The following oral surgery procedures:
 - a. Alveoloplasty.
 - b. Cyst removal.
 - c. Excision of hyperplastic tissue.
 - d. Frenectomy.
 - e. Removal of exostosis.
 - f. Stomatoplasty.
 - g. Surgical exposure of impacted tooth to aid eruption.
 - h. Tooth transplantation.
 - i. Tooth replantation.
 - j. Vestibuloplasty.
9. The following prosthodontic services:
 - a. Fixed bridges.
 - b. Full and partial dentures.
 - c. Denture adjustments, relining or rebasing.
10. The following periodontal services:
 - a. Gingival curettage, gingivectomy, mucogingival surgery, and osseous surgery (which includes charges for osseous grafts).
 - b. Periodontal appliances.
 - c. Periodontal prophylaxis.
 - d. Scaling and root planing.
 - e. Soft tissue grafts.

Covered dental charges under this group policy include only the charges incurred for dental services described as Preventive Dental Services and Basic Dental Services in the Dental Services List.

Dental Definitions

Other definitions appear within the text of this Dental Insurance and in the General Definitions section.

Dental Hygienist. The term "dental hygienist" means only a person: (a) who has been trained in an accredited school; (b) who is licensed by the state in which he is practicing the art of dental prophylaxis; and (c) who is practicing under the direction and supervision of a dentist.

Dentist. The term "dentist" means only a person who: (a) is licensed to practice dentistry; and (b) is acting within the scope of the license. The term "dentist" shall include a physician who provides dental services within the scope of the physician's license.

Dental Preferred Provider. The term "dental preferred provider" means only a dentist who is listed in the latest edition of the directory of dental preferred providers that applies to the group policy.

Dental Non-Preferred Provider. The term "dental non-preferred provider" means only a dentist who is not listed in the latest edition of the directory of dental preferred providers that applies to the group policy.

Orthodontia Treatment. The term "orthodontia treatment" means the movement of the teeth through the bone by means of an active appliance to correct a malocclusion of the mouth.

Program of Treatment. The term "program of treatment" means all treatment that is done or is to be done in the oral cavity at one or more sessions as the result of the initial diagnosis. The program shall include the treatment for any complications that arise during the program.

Sound Natural Tooth. The term "sound natural tooth" means a tooth that: (a) is organic and formed by the natural development of the body (not manufactured); (b) has not been extensively restored; and (c) has not become extensively decayed or involved in periodontal disease.

TMJ Disorder. "TMJ" stands for temporal mandibular joint. The term "TMJ disorder" means a disorder, disease, or dysfunction of the TMJ.

Treatment Plan. The term "treatment plan" means the attending dentist's report of a recommended program of treatment. The report must be written on a form satisfactory to the Claims Administrator, per agreement with Us, and must:

1. itemize the proposed procedures;
2. list the charge for each procedure; and
3. be accompanied by any appropriate diagnostic materials as may be required by Us and the Claims Administrator.

Dental Services List

Covered dental charges include the charges incurred for the services shown below, provided they meet all of the tests of the covered dental charge definition. If a procedure is not shown in this list and is not excluded by any of the terms of the group policy, the Claims Administrator, per agreement with Us, shall determine which category of dental service the procedure falls under.

Preventive Dental Services

1. Fluoride treatments. Covered dental charges for fluoride treatments are limited to the charges incurred for one such treatment rendered to a dependent child who is under 19 years of age during any one calendar year.
2. Oral examinations. Covered dental charges for oral examinations are limited to the charges incurred for one such examination during any one calendar year.
3. Routine dental prophylaxis. Covered dental charges for routine dental prophylaxis are limited to the charges incurred for such procedure during the first dental visit of any one calendar year at which any such procedure is performed. In no event will covered dental charges for routine and periodontal prophylaxis include the charges incurred for more than four such procedures during any one calendar year.
4. Bitewing X-rays. Covered dental charges for bitewing X-rays are limited to the charges incurred for such one X-ray during any one calendar year.
5. Extra-oral X-rays. Covered dental charges for extra-oral X-rays are limited to the charges incurred for one such X-rays during any one calendar year.
6. Individual periapical X-rays. Covered dental charges for individual periapical X-rays are limited to the charges incurred for two such X-rays any one calendar year.
7. Occlusal X-rays. Covered dental charges for occlusal X-rays are limited to the charges incurred for one such X-rays during any one calendar year.
8. Panoramic and complete mouth survey X-rays. During any period of five calendar years, covered dental charges include the charges incurred for one panoramic X-ray or one complete mouth survey X-ray, but not both. As used here, the term "complete mouth survey X-ray" means bitewing X-rays and 10 or more periapical X-rays.

Basic Dental Services

1. Bacteriologic cultures.
2. Biopsies.
3. Casts (diagnostic models).
4. Extractions, simple and surgical, including extractions of impacted teeth.
5. Incision and drainage.
6. Injection of therapeutic drug.
7. Pin retention.
8. Recementation of crowns, inlays, onlays, veneers and bridges.
9. Repair of bridges and full or partial dentures. Covered dental charges include the charges incurred for a repair to a bridge, or to a full or partial denture, only if the repair is performed more than 12 consecutive months after the initial insertion of the bridge or denture.
10. Basic restorations (fillings) --amalgam, resin, and silicate. If the incisal surface is not involved, Dental Benefits will be paid for the covered dental charges incurred:(a) for a two-surface restoration on an anterior tooth on the same basis as Dental Benefits are paid for a single-surface restoration; and (b) for a three surface restoration on an anterior tooth on the same basis as Dental Benefits are paid for a two-surface restoration.
11. Sedative fillings, and palliative treatment. A separate Dental Benefit is payable for a sedative filling or for palliative treatment only if no other dental service, other than X-rays, is rendered during the dental visit.
12. Emergency palliative treatment.
13. Sealants. Covered dental charges include the charges incurred for sealants on the occlusal surfaces of unrestored permanent first and second molars only, and are limited to the charges for one sealant per tooth rendered to a dependent child who is under 14 years of age during the dependent child's lifetime.
14. Space maintainers. Covered dental charges include the charges incurred for space maintainers only if they are rendered to a dependent child who is under 17 years of age.
15. General anesthesia and I.V. sedation. A separate Dental Benefit is payable for general anesthesia or I.V. sedation only if extractions are performed in 3 or more quadrants of the mouth. General anesthesia or IV sedation is eligible for the first 30 minutes only. Additional minutes at the same session are not eligible.
16. The following endodontic services:
 - a. Apicoectomy and retrograde filling.
 - b. Hemisection.
 - c. Pulpotomy.
 - d. Root canal therapy.
 - e. Pulp capping.
 - f. Root amputation.
 - g. Bleaching after root canal therapy. Covered dental charges include the charges incurred for bleaching of an endodontically treated tooth only if the tooth is not restored with a crown, inlay, onlay, or veneer.T
17. The following periodontal services:
 - a. Periodontal surgery: gingivectomy; mucogingival surgery; and osseous surgery. Covered dental charges for gingivectomy, mucogingival surgery, and osseous surgery (which includes charges for osseous grafts and guided tissue regeneration) are limited to the charges incurred for one of these procedures per area of the mouth during any period of three calendar years.
 - b. Periodontal appliances.
 - c. Periodontal maintenance. A Dental Benefit will be paid for periodontal maintenance only if the procedure is performed at least three calendar months after periodontal surgery. For the 36-month period following the date of such surgery, covered dental charges incurred for periodontal maintenance are limited to the charges for four such procedures during any twelve-month period. Thereafter, the Claims Administrator, per

agreement with Us, will pay for periodontal maintenance only if the covered person submits to the Claims Administrator a treatment plan made out by the attending dentist and receives the Claims Administrator's approval of such treatment. In no event will covered dental charges for routine and periodontal maintenance include the charges incurred for more than four such procedures during any one calendar year. Periodontal maintenance procedures are covered as a routine prophylaxis benefit if no active therapy has been performed. Active periodontal therapy means periodontal surgery or scaling and root planing.

- d. Provisional splinting.
- e. Scaling and root planing. Covered dental charges for scaling and root planing are limited to the charges incurred for one such service per quadrant during any period of two calendar years. Dental Benefits for all full mouth scaling and root planing procedures performed on the same day will be limited to the allowance for one quadrant of scaling and root planing.
- f. Soft tissue grafts.

Dental Insurance: High Option Plan

We will pay a Dental Benefit as determined below for the covered dental charges a covered person incurs while insured for the Dental Insurance.

Dental Benefits And Covered Charges Benefit

A "Dental Benefit" is the amount, if any, that will be paid for covered dental charges incurred by a covered person. The amount of a Dental Benefit is the amount the Claims Administrator, per agreement with Us, calculates in the steps shown below:

1. The charges for which a claim is submitted to the Claims Administrator are tested against the Covered Dental Charge definition. Those that meet all of the tests are the covered dental charges.
2. Any deductible amount that applies to the charges and that has not yet been met is subtracted from the amount of covered dental charges.
3. The amount of covered dental charges that remain is then multiplied by the applicable dental percentage payable.
4. If any part of the amount calculated exceeds an applicable benefit maximum, then that part is subtracted and the remainder is the amount of the Dental Benefit.

Dental Deductible

The Dental Deductible shown in the Schedule of Benefits:

1. applies to all covered dental charges unless the Schedule of Benefits states otherwise;
2. applies separately to each covered person during each calendar year; and
3. must be accumulated during the calendar year.

Only those charges to which a deductible applies can be used to satisfy that deductible.

Family Deductible Maximum. If the Family Deductible Maximum shown in the Schedule of Benefits is satisfied in any one calendar year by covered persons in your family, then the Dental Deductible will not be applied to any other charges incurred in that calendar year by covered persons in your family. As used here, "family" means you and all of your dependents that are insured for the Dental Insurance.

Dental Percentage Payable

Two items determine the percentage that is used to calculate the Dental Benefit for a covered dental charge: (a) the category of dental service that includes the service for which the charge is made; and (b) the date the charge is incurred.

The Dental Percentage Payable table in the Schedule of Benefits shows the percentages that apply. They are shown by category of service and year of dental coverage. The categories are defined by the Dental Services List. The term "year of dental coverage" is in the Dental Definitions.

Dental Benefit Maximum

The Claims Administrator, per agreement with Us, will not pay more than the Calendar Year Maximum shown in the Schedule of Benefits for all covered dental charges incurred by a covered person during any one calendar year.

Covered Dental Charges

A "covered dental charge" is a charge that meets all of the tests listed below:

1. It is made by a dentist or dental hygienist for a covered dental service that is furnished to a covered person.
2. It is incurred by a covered person while the covered person is insured for the Dental Insurance. A charge is deemed to be incurred at the time the service is rendered for which the charge is made. The date a dental service is deemed to be rendered is shown in the Date Dental Service Rendered provision below.
3. It is not excluded by the Dental Exclusions or the General Health Limitations.
4. It is for a service that: (a) is essential for the necessary care of the patient's teeth and supporting tissue; (b) is performed by a dentist or dental hygienist; (c) has a reasonably favorable prognosis; (d) is generally accepted professional practice and meets professionally recognized standards; and (e) is the least expensive procedure that will produce a result that meets professionally recognized standards.

- It does not exceed the smallest of the covered charge limits that apply to the service for which the charge is made. The part of a charge that does not exceed the smallest of the covered charge limits shall be considered a covered dental charge if it meets all of the tests in this provision.

Emergency Palliative Treatment Benefit

Charges made for emergency palliative treatment are covered dental charges, regardless of whether the charges are made by a dental preferred provider or a dental non-preferred provider. The term "emergency palliative treatment" means dental services provided after the sudden onset of a dental condition manifesting itself by the acute symptom of severe pain.

Covered Charge Limits

The "covered charge limits" that apply to each dental service are the lesser of the billed charge and: (a) the usual charge for the service; (b) the customary charge for the service; (c) any limit specified in the Dental Services List; and (d) for dental charges made by a dental preferred provider, the contracted charge for the service.

Predetermination of Benefits

The Claims Administrator, per agreement with Us, suggests that a predetermination of benefits take place when a dentist estimates that the charges for a program of treatment will be more than \$400. As used here, "predetermination of benefits" means that before a covered person receives any such treatment, he: (a) submits to the Claims Administrator a treatment plan made out by the attending dentist; and (b) gets the Claims Administrator's estimate of the Dental Benefits for the program of treatment. This provision shall not apply to charges for emergency treatment.

Date Dental Service Rendered

For the purpose of determining Dental Benefits, a covered dental service shall be deemed to be rendered on the date shown below that applies to the service. A temporary dental service will be deemed an integral part of the final dental service rather than a separate dental service.

Dental Service Date Deemed Rendered

Dentures or Partial Dentures	The date the final impression is taken.
Fixed Bridges, Crowns, Inlays, Onlays	The date the teeth are first prepared.
Root Canal Therapy	The date the pulp chamber is opened and canals explored to the apex.
Periodontal Surgery	The date the surgery is actually performed.
All Other Services	The date the service is performed.

Benefits After Termination of Insurance

The only Dental Benefits that will be paid on behalf of a covered person after the covered person's Dental Insurance ends shall be for covered dental charges incurred for treatment that: (a) is rendered while the covered person is insured for the Dental Insurance; and (b) is completed within 30 days of the date the covered person's Dental Insurance ends.

Dental Proof

The written proof required by Us and the Claims Administrator shall include the following items:

- A complete dental chart that shows extractions, missing teeth, fillings, prostheses, periodontal pocket depths, orthodontic relationships, and the date of any previous treatment.
- An itemized bill for all dental care.
- X-rays and study models.
- Laboratory and hospital reports.

Dental Exclusions

No Dental Benefit will be paid for any charge excluded by the General Health Limitations or for any of the items listed below:

- Procedure that is not necessary or that does not meet professionally recognized standards.
- Procedure relating to: (a) the change of vertical dimension; (b) restoration of occlusion; (c) bite registration; or (d) bite analysis.
- Procedure that is performed mainly to improve the appearance of the covered person. To correct abrasion, erosion, attrition, bruxism, abfraction; or teeth that are not periodontally sound or which have a questionable prognosis as determined by us.
- That is considered cosmetic dentistry including, but not limited to porcelain on a crown, abutment or pontics posterior to the second bicuspid; composite restorations on molar and/or bicuspid teeth. Services done to alter the shape or size of teeth or congenital malformations.
- Replacement of an item that has been lost or stolen.
- Charges made by a dentist's office for a broken or missed appointment, duplicate X-rays, sterilization of equipment, or for the filing of a claim.
- Orthodontia treatment or replacement of orthodontic retainers.
- The following items and services: (a) an athletic mouthguard; (b) a specialized appliance; (c) a precision or semiprecision attachment; (d) a denture duplication; (e) oral hygiene instruction; (f) treatment for fractures; (g) myofunctional therapy; (h) orthognathic surgery, sleep disorder appliance, treatment splints.

9. Charge: (a) for a procedure for which any benefit is provided under a medical or orthodontia expense plan that is supplied by the Policyholder; or (b) that is used to satisfy a deductible under any such plan.
10. Treatment of TMJ disorders, including jaw joint problems or physical therapy.
11. Local anesthesia, behavior management, conscious sedation.
12. Initial placement of full or partial dentures, bridges or crowns to replace functional natural teeth that are:
 - a. Congenitally missing; or
 - b. Lost before insurance under this Plan is in effect except as noted below.

We will pay for initial placement of full or partial dentures or bridges to replace loss of functional natural teeth, but only if lost;

- a. While insured by the Policy; or
- b. For a dependent child whose teeth were extracted before age 17; and
- c. If the child was insured by this plan at the time of the extraction; and
- d. After any applicable waiting period for major dental services is met.

This benefit includes necessary adjustments, relines or rebases during the first six months following the date of placement.

13. Replacement within 5 years of the last placement for full and partial dentures, bridges, inlays, onlays, crown, veneers or implants.

This exclusion does not apply if the replacement is necessary because of;

- a. Extraction of a functioning natural tooth; and if the replacement is completed within 12 months of the date of the injury or extraction.
- b. An injury to sound natural teeth (other than a chewing injury) sustained in an accident.

14. Crowns, bridges, inlays, onlays, veneers or partial dentures that;

- a. Is for a tooth that can be restored by other means;
- b. Is for the purpose of periodontal splinting;
- c. Is for a tooth that does not demonstrate extensive decay or fracture.

Dental Definitions

Other definitions appear within the text of this Dental Insurance and in the General Definitions section.

Dental Hygienist. The term "dental hygienist" means only a person: (a) who has been trained in an accredited school; (b) who is licensed by the state in which he is practicing the art of dental prophylaxis; and (c) who is practicing under the direction and supervision of a dentist.

Dentist. The term "dentist" means only a person who: (a) is licensed to practice dentistry; and (b) is acting within the scope of the license. The term "dentist" shall include a physician who provides dental services within the scope of the physician's license.

Dental Preferred Provider. The term "dental preferred provider" means only a dentist who is listed in the latest edition of the directory of dental preferred providers that applies to the group policy.

Dental Non-Preferred Provider. The term "dental non-preferred provider" means only a dentist who is not listed in the latest edition of the directory of dental preferred providers that applies to the group policy.

Orthodontia Treatment. The term "orthodontia treatment" means the movement of the teeth through the bone by means of an active appliance to correct a malocclusion of the mouth.

Program of Treatment. The term "program of treatment" means all treatment that is done or is to be done in the oral cavity at one or more sessions as the result of the initial diagnosis. The program shall include the treatment for any complications that arise during the program.

Sound Natural Tooth. The term "sound natural tooth" means a tooth that: (a) is organic and formed by the natural development of the body (not manufactured); (b) has not been extensively restored; and (c) has not become extensively decayed or involved in periodontal disease.

TMJ Disorder. "TMJ" stands for temporal mandibular joint. The term "TMJ disorder" means a disorder, disease, or dysfunction of the TMJ.

Treatment Plan. The term "treatment plan" means the attending dentist's report of a recommended program of treatment. The report must be written on a form satisfactory to the Claims Administrator, per agreement with Us, and must:

1. itemize the proposed procedures;
2. list the charge for each procedure; and
3. be accompanied by any appropriate diagnostic materials as may be required by the Claims Administrator and Us.

Year of Dental Coverage. A "year of dental coverage" means a period of 12 consecutive months or less during which a covered person is insured for the Dental Insurance. A year of dental coverage starts on the date the covered person's Dental Insurance starts and on each anniversary of that date. The year ends on the earlier of:
(a) the day prior to the next anniversary; or (b) the date the covered person's Dental Insurance ends.

Dental Services List

Covered dental charges include the charges incurred for the services shown below, provided they meet all of the tests of the covered dental charge definition. If a procedure is not shown in this list and is not excluded by any of the terms of the group policy, the Claims Administrator, per agreement with Us, shall determine which category of dental service the procedure falls under.

Preventive Dental Services

1. Fluoride treatments. Covered dental charges for fluoride treatments are limited to the charges incurred for one such treatment rendered to a dependent child who is under 19 years of age during any one calendar year.
2. Oral examinations. Covered dental charges for oral examinations are limited to the charges incurred for one such examination during any one calendar year.
3. Routine dental prophylaxis. Covered dental charges for routine dental prophylaxis are limited to the charges incurred for such procedure during the first dental visit of any one calendar year at which any such procedure is performed. In no event will covered dental charges for routine and periodontal prophylaxis include the charges incurred for more than four such procedures during any one calendar year.
4. Bitewing X-rays. Covered dental charges for bitewing X-rays are limited to the charges incurred for such one X-ray during any one calendar year.
5. Extra-oral X-rays. Covered dental charges for extra-oral X-rays are limited to the charges incurred for one such X-rays during any one calendar year.
6. Individual periapical X-rays. Covered dental charges for individual periapical X-rays are limited to the charges incurred for two such X-rays any one calendar year.

7. Occlusal X-rays. Covered dental charges for occlusal X-rays are limited to the charges incurred for one such X-rays during any one calendar year.
8. Panoramic and complete mouth survey X-rays. During any period of five calendar years, covered dental charges include the charges incurred for one panoramic X-ray or one complete mouth survey X-ray, but not both. As used here, the term "complete mouth survey X-ray" means bitewing X-rays and 10 or more periapical X-rays.

Basic Dental Services

1. Bacteriologic cultures.
2. Biopsies.
3. Casts (diagnostic models).
4. Extractions, simple and surgical, including extractions of impacted teeth.
5. Incision and drainage.
6. Injection of therapeutic drug.
7. Pin retention.
8. Recementation of crowns, inlays, and bridges.
9. Repair of bridges and full or partial dentures. Covered dental charges include the charges incurred for a repair to a bridge, or to a full or partial denture, only if the repair is performed more than 12 consecutive months after the initial insertion of the bridge or denture.
10. Basic restorations (fillings) --amalgam, resin, and silicate. If the incisal surface is not involved, Dental Benefits will be paid for the covered dental charges incurred:(a) for a two-surface restoration on an anterior tooth on the same basis as Dental Benefits are paid for a single-surface restoration; and (b) for a three-surface restoration on an anterior tooth on the same basis as Dental Benefits are paid for a two-surface restoration.
11. Sedative fillings and palliative treatment. A separate Dental Benefit is payable for a sedative filling or for palliative treatment only if no other dental service, other than X-rays, is rendered during the dental visit.
12. Emergency palliative treatment.
13. Sealants. Covered dental charges include the charges incurred for sealants on the occlusal surfaces of unrestored permanent first and second molars only, and are limited to the charges for one sealant per tooth rendered to a dependent child who is under 14 years of age during the dependent child's lifetime.
14. Space maintainers. Covered dental charges include the charges incurred for space maintainers only if they are rendered to a dependent child who is under 17 years of age.
15. General anesthesia and I.V. sedation. A separate Dental Benefit is payable for general anesthesia or I.V. sedation only if extractions are performed in 3 or more quadrants of the mouth. General anesthesia or I.V. sedation is eligible for the first 30 minutes only. Additional minutes at the same session are not eligible.
16. The following endodontic services:
 - a. Apicoectomy and retrograde filling.
 - b. Hemisection.
 - c. Pulpotomy.
 - d. Root canal therapy.
 - e. Pulp capping.
 - f. Root amputation.
 - g. Bleaching after root canal therapy. Covered dental charges include the charges incurred for bleaching of an endodontically treated tooth only if the tooth is not restored with a crown, inlay, onlay, or veneer.
17. The following periodontal services:
 - a. Periodontal surgery: gingivectomy; mucogingival surgery; and osseous surgery. Covered dental charges for gingivectomy, mucogingival surgery, and osseous surgery (which includes charges for osseous grafts and guided tissue regeneration) are limited to the charges incurred for one of these procedures per area of the mouth during any period of three calendar years.
 - b. Periodontal appliances.
 - c. Periodontal maintenance. A Dental Benefit will be paid for periodontal maintenance only if the procedure is performed at least three calendar months after periodontal surgery. For the 36-month period following the date of such surgery, covered dental charges incurred for periodontal maintenance are limited to the charges for four such procedures during any twelve-month period. Thereafter, the Claims Administrator, per agreement with Us, will pay for periodontal maintenance only if the covered person submits to the Claims Administrator a treatment plan made out by the attending dentist and receives the Claims Administrator's approval of such treatment. In no event will covered dental charges for routine and periodontal maintenance include the charges incurred for more than four such procedures during any one calendar year. Periodontal maintenance procedures are covered as a routine prophylaxis benefit if no active therapy has been performed. Active periodontal therapy means periodontal surgical or scaling and root planing.
 - d. Provisional splinting.
 - e. Scaling and root planing. Covered dental charges for scaling and root planing are limited to the charges incurred for one such service per quadrant during any period of two calendar years. Dental Benefits for all full mouth scaling and root planing procedures performed on the same day will be limited to the allowance for one quadrant of scaling and root planing.
 - f. Soft tissue grafts.

Major Dental Services

1. Crowns. For a covered person who is under 17 years of age, covered dental charges include the charges incurred for a crown only if it is stainless steel.
2. Crown build-ups.
3. Inlays and onlays. Covered dental charges include the charges incurred for: (a) an inlay only if it is provided with an onlay on the same tooth; and (b) an inlay or an onlay only if it is rendered to a covered person who is 17 years of age or older.
4. Labial veneers.
5. Occlusal adjustment.
6. Posts and cores. Covered dental charges include the charges incurred for posts and cores only if they are provided following root canal therapy on the same tooth.
7. Implants. Covered dental charges include the charges incurred for implants only if they are intended to replace one or more sound natural teeth which are extracted while the covered person is insured for the Dental Insurance; and only if they are rendered to a covered person who is 17 years of age or older. A Dental Benefit will be paid for the maintenance or repair of an implant only if the procedure is performed at least 12 consecutive months after the initial insertion of the implant.
8. The following oral surgery procedures:
 - a. Alveoloplasty.
 - b. Cyst removal.
 - c. Excision of hyperplastic tissue.
 - d. Frenectomy. Covered dental charges include the charges incurred for a frenectomy only if the procedure is not performed in connection with periodontal surgery.
 - e. Removal of exostosis.
 - f. Root recovery.
 - g. Stomatoplasty.
 - h. Surgical exposure of impacted tooth to aid eruption.
 - i. Tooth transplantation.
 - j. Tooth replantation.
 - k. Vestibuloplasty.
9. The following prosthodontic services:
 - a. Fixed bridges. Covered dental charges include the charges incurred for a fixed bridge only if the bridge is rendered to a covered person who is 17 years of age or older.
 - b. Full and partial dentures.
 - c. Denture adjustments, relining or rebasing. Covered dental charges do not include the charges incurred for denture adjustment, or for denture relining or rebasing, during the six-month period following the initial insertion of the denture. Thereafter, covered dental charges for denture adjustments, relining or rebasing are limited to the charges incurred for one of these procedures during any period of three calendar years.

Dependent Child Orthodontia Insurance

(In Force Only When the High Option Plan of Dental Insurance Has Been Elected)

Claims Administrator, per agreement with Us, will pay an Orthodontia Benefit as determined below for the covered orthodontia charges a dependent child incurs while insured for the Orthodontia Insurance.

Orthodontia Benefits And Covered Charges Benefit

An "Orthodontia Benefit" is the amount that will be paid for covered orthodontia charges incurred by a dependent child. The amount of the Orthodontia Benefit will be the Orthodontia Percentage Payable of the covered orthodontia charges incurred up to the dependent child's Orthodontia Maximums. The Orthodontia Percentage Payable and the Orthodontia Maximums are shown in the Schedule of Benefits.

An Orthodontia Benefit shall be paid as set forth in the Payment of Treatment Plan Benefits provision below.

Orthodontia Maximums

The Claims Administrator, per agreement with Us, will not pay more than the Orthodontia Calendar Year Maximum shown in the Schedule of Benefits for all covered orthodontia charges incurred by a dependent child during any one calendar year.

The Claims Administrator, per agreement with Us, will not pay more than the Orthodontia Lifetime Maximum shown in the Schedule of Benefits for all covered orthodontia charges incurred by a dependent child during his lifetime.

Covered Orthodontia Charges

A "covered orthodontia charge" is a charge that meets all of the tests listed below:

1. It is made by a dentist for an orthodontia service that is furnished to a dependent child.
2. It is incurred by a dependent child while the dependent child is insured for the Orthodontia Insurance. A charge is deemed to be incurred at the time the service is rendered for which the charge is made. The date an orthodontia service is deemed to be rendered is shown in the Date Orthodontia Service Rendered provision below.

3. It is not excluded by the Deferred Orthodontia Coverage, Orthodontia Exclusions, or the General Health Limitations.
4. It is for a cephalometric X-ray, the movement of a tooth for periodontal purposes, the surgical exposure of an impacted tooth, or orthodontia treatment, and is the least expensive procedure that will produce a result that meets professionally recognized standards.
5. It does not exceed the smallest of the covered charge limits that apply to the service for which the charge is made. The part that does not exceed the smallest of the covered charge limits shall be considered a covered orthodontia charge if it meets all of the tests in this provision.

The covered orthodontia charges for a program of treatment for which a treatment plan is not given to the Claims Administrator shall be limited as stated in the Predetermination of Benefits provision.

Covered Charge Limits

The "covered charge limits" that apply to each orthodontia service are the lesser of the billed charge and: (a) the usual charge for the service; (b) the customary charge for the service; (c) for charges made by a dental preferred provider, the contracted charge for the service.

The terms "dental preferred provider" and "dental non-preferred provider", as used here, are defined in the Dental Insurance section.

Predetermination of Benefits

The Claims Administrator, per agreement with Us, requires a predetermination of benefits. As used here, "predetermination of benefits" means that, before the dependent child receives any orthodontia treatment, the dependent child must: (a) give to the Claims Administrator a treatment plan made out by the attending dentist; and (b) get the Claims Administrator's estimate of the Orthodontia Benefits for that program of treatment.

If a required treatment plan is not submitted, The Claims Administrator, in its sole discretion: (a) may limit the amount it considers covered orthodontia charges to the covered orthodontia charges for the least expensive alternate procedures that will produce a result that meets professionally recognized standards; or (b) in the absence of satisfactory orthodontia proof, may deny the claim.

Payment of Treatment Plan Benefits

The Orthodontia Benefit for a program of treatment shall be paid on a calendar quarter basis as follows:

1. Single Charge Program. If the program does not have a separate charge for appliance insertion, a payment will be made in each calendar quarter that the program is in progress. The payment shall be the amount that results from dividing: (a) The Claims Administrator's estimate of the total Orthodontia Benefit for the program; by (b) the number of calendar quarters that will be required to complete the program.
2. Itemized Charge Program. If the program has a separate charge for appliance insertion, a payment for the first calendar quarter that the plan is in progress will be made. The payment shall be 25% of the Claims Administrator's estimate of the total Orthodontia Benefit for the program. The payment for each subsequent calendar quarter that the program is in progress will be equal to the amount that results from dividing: (a) the remaining Orthodontia Benefit for the program; by (b) the number of calendar quarters required to complete the program.

No Orthodontia Benefit shall be paid after a dependent child's Orthodontia Insurance ends except as stated in the Benefits After Termination of Insurance provision.

A "calendar quarter" is each period of three months that starts on: January 1, April 1, July 1, and October 1.

Date Orthodontia Service Rendered

For the purpose of determining Orthodontia Benefits, a covered orthodontia service shall be deemed rendered on the date shown below that applies to the service:

Orthodontia Service	Date Deemed Rendered
Orthodontia treatment up to and including the initial insertion of bands or appliance	The insertion date of the band or appliance
Orthodontia treatment subsequent to the initial insertion of bands or appliance	The date the treatment is performed if it is completed on the same date; otherwise the date the treatment is completed.
Other orthodontia services	The date the service is performed if it is completed on the same date; otherwise the date the service is completed.

Benefits After Termination of Insurance

After the date a dependent child's Orthodontia Insurance ends, the only Orthodontia Benefits that will be paid on behalf of the dependent child shall be for covered orthodontia charges that were incurred while the dependent child was insured for the Orthodontia Insurance.

Orthodontia Proof

The written proof the Claims Administrator and We require shall include the following items:

1. Full mouth dental X-rays.
2. Cephalometric X-rays and analysis.
3. Study models.
4. A brief questionnaire that tells:
 - a. the degree of overjet, overbite, crowding, open bite;
 - b. if the teeth are impacted, are in crossbite, or are congenitally missing;
 - c. all dates on which treatment was rendered;
 - d. the total charge for the treatment.

Deferred Orthodontia Coverage And Orthodontia Exclusions

Deferred Orthodontia Coverage

Charges that are incurred for orthodontia treatment during the 12-month period that follows the date a dependent child's Orthodontia Insurance starts will not be covered orthodontia charges.

For a dependent child who becomes insured under the group policy and who was covered under a similar orthodontia plan immediately prior to their eligibility date for the group policy, the deferment period shown above will either be:

1. reduced by the length of time the person was continuously covered under the similar orthodontia plan; or
2. changed to be the same as the deferment period that would have applied to that person under the prior orthodontia plan if that plan had not been replaced;

whichever time period is shorter. A dependent's eligibility date is described in the Eligibility Date provision of the Dependents Eligibility section.

Orthodontia Exclusions

No Orthodontia Benefit will be paid for any charge excluded by the General Health Limitations or for any:

1. procedure that is not necessary or that does not meet professionally recognized standards;
2. replacement or repair of an appliance furnished as a part of a program of treatment;
3. fee charged for: (a) a consultation; or (b) the planning of treatment; except when the consultation or planning is for preparing a treatment plan that is submitted to the Claims Administrator for predetermination of benefits;
4. charges made by a dentist's office for a broken or missed appointment, duplicate X-rays, sterilization of equipment, or for the filing of a claim.
5. service for which a benefit is paid or payable under the Dental Insurance of the group policy;
6. charge: (a) for a procedure for which any benefit is provided under a medical expense plan that is supplied by the Policyholder; or (b) that is used to satisfy a deductible under any such plan.

Orthodontia Definitions

The Dental Definitions of the Dental Insurance shall apply to the Orthodontia Insurance when those terms are used in the Orthodontia Insurance.

Coordination Of Benefits

The Coordination of Benefits provisions apply to each covered person under the group policy.

Effect on Benefits

When a covered person is entitled to benefits or services under more than one plan, the rules shown in the Order of Benefit Determination section below will be used to decide which plan is the principal plan. If the group policy:

1. is the principal plan among all of the plans that cover the covered person, then its benefits will be determined without taking into account the benefits or services of any other plan.
2. is not the principal plan, then We may reduce its benefits. They will be reduced so that all of the benefits and services provided by all of the plans during each claim determination period will not be more than 100% of the allowable expenses incurred by the covered person. The benefits provided by a plan include those that would have been provided if a claim had been duly made.

The benefits of the group policy will never be greater than the sum of the benefits that would have been paid if there were no other plan covering the covered person.

Plan. The term "plan" means a plan that provides benefits or services by or through any:

1. group insurance;
 2. group practice or prepayment coverage;
 3. group service plan;
 4. method of coverage for persons in a group other than as shown in items 1, 2, and 3; or
 5. coverage that is required or provided by law;
- except that the term shall not include franchise insurance.

The term "plan" shall also include "no-fault" motor vehicle insurance where the law does not forbid it.

Principal Plan. With respect to any two plans that cover a covered person on whose expenses a claim is based, the "principal plan" is the plan under which benefits will be determined first.

Allowable Expense. The term "allowable expense" means any necessary, reasonable, and customary item of expense that is, at least in part, a covered expense under one or more of the plans that cover the covered person. When a plan provides a service, the service will be deemed to be both an allowable expense and a benefit paid.

Claim Determination Period. The term "claim determination period" means a calendar year.

Anti-duplication Provision. An "anti-duplication provision" is a provision that reserves to a plan the right to consider the benefits or services of other plans in determining its benefits.

Order of Benefit Determination. The following rules determine which plan is the principal plan.

1. If the other plan is not primarily a dental plan, this plan is the principal plan.
2. If the other plan is a dental plan, the rules set forth below are applied.

Plans Without Anti-duplication Provisions. When one of any two dental plans does not include an anti-duplication provision, then that plan will be the principal plan. If any part of a dental plan is not subject to an anti-duplication provision, then that part will be deemed to be a separate plan and will be the principal plan.

Plans With Anti-duplication Provisions. These rules will be used to decide which of any two dental plans is the principal plan when both contain an anti-duplication provision. The first rule listed that describes one, but not both, of the plans will identify the principal plan.

1. The plan that covers the covered person other than as a dependent.
2. The plan that covers the covered person as a dependent of the parent whose birthday occurs earlier in a calendar year. If both parents have the same birthday, the plan that has covered the parent for the longer period of time. The rule of the other plan will be used in place of this rule when: (a) the rule of the other plan is not based on the birthday of the parent; and (b) the result of using this rule is that the plans do not agree on which plan is the principal plan.
3. The plan that covers the covered person through present employment instead of a plan that covers the covered person through prior employment. Through prior employment means as a laid off or retired employee or as a dependent of a laid off or retired employee. This rule will not be used when: (a) the other plan does not include a similar rule; and (b) the result of using this rule is that the plans do not agree on which plan is the principal plan.
4. The plan that has covered the covered person for the longer period of time.

Exception to Rule 2. If the covered person is a dependent child of parents who are divorced or separated, then the following rules will be used in place of rule 2:

1. The plan of the parent who has been assigned the financial duty for the child's health care by a court decree.
2. The plan of the parent who has custody of the child.
3. The plan of the stepparent who is married to the parent with custody of the child.
4. The plan of the parent who does not have custody of the child.

Right to Information, Payment, and Recovery of Payment

To meet the intent of the Coordination of Benefits provisions or an anti-duplication provision of any other plan:

1. the Claims Administrator, per agreement with Us, may, in a way allowed by law, give or get any information that is needed to decide the benefits that are payable. A covered person must declare coverage under any other plans and give to the Claims Administrator the information they need to meet the intent of this provision.
2. the Claims Administrator, per agreement with Us, shall have the right to pay to any organization the amount that organization has paid that should have been paid by the Claims Administrator. An amount so paid will be deemed to be a benefit paid under the group policy. To the extent of the payment, We will have no more liability under the group policy.

If the Claims Administrator has paid more than it should have paid to meet the intent of this provision, We may recover the excess amount from one or more of the following, as We may decide:

1. any person to, or for, or with respect to whom the payment was made;
2. any other insurance company; or
3. any other organization.

Right Of Recovery

If a covered person incurs expenses for sickness or injury that occurred due to the negligence of a third party:

1. We have the right to reimbursement of all benefits the Claims Administrator paid from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the covered person, the covered person's parents, if the covered person is a minor, or covered person's legal representative as a result of that sickness or injury; and
2. We are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claims Administrator paid for that sickness or injury.

We shall have the right to first reimbursement out of all funds of the covered person, the covered person's parents, if the covered person is a minor, or the covered person's legal representative, is or was able to obtain for the same expenses the Claims Administrator has paid as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that we may reasonably require in order to obtain Our rights under this provision. This provision applies whether or not the third party admits liability.

Notice, Proof, And Payment Of Health Claims

Time of Notice

You must send written notice of a claim to the Claims Administrator at the address shown in the General Definitions section of the policy, within 20 days after an expense or loss occurs. If you cannot send it within that time, you must send it as soon as reasonably possible.

Forms

When the Claims Administrator receives the notice of claim, the Claims Administrator will send a claim form to you for filing proof of loss. If the Claims Administrator does not send the claim form within 15 days, you will be deemed to comply with the proof of loss requirements by sending written proof of loss as set forth below. The written proof must show: (a) the date the loss occurred or began; (b) the cause of the loss; and (c) the extent of the loss.

Proof of Loss

In the case of a health claim for expense or loss for which a periodic benefit is paid while the loss continues, you must send written proof of loss:

1. to the Claims Administrator at the address shown in the General Definitions section of the policy; and
2. within 90 days after the end of each period for which the benefits are to be paid.

In the case of a health claim for any other expense or loss, you must send written proof of loss to the Claims Administrator within 90 days after the date the expense or loss is incurred. The Claims Administrator will not deny or reduce a claim due to the fact that you are not able to send the proof of loss within 90 days, if you send the proof of loss to the Claims Administrator:

1. as soon as it is reasonably possible to do so; and
2. in no case, but for the lack of legal capacity, more than one year after it is otherwise required.

Time of Payment

The Claims Administrator will pay claims as soon as they receive due written proof of loss.

To Whom Benefits Are Payable

Any health benefits payable for loss of your life will be paid to the beneficiary you have designated to receive such benefits. Except as set forth below, any other benefits that have not been paid when you die may be paid, at Our option, either to your beneficiary or to your estate. All other amounts will be paid to you.

Exception for Medical Assistance Benefits. If a public health department of a state:

1. pays all or part of the cost of services and supplies furnished to a covered person for which benefits are payable under the group policy; and
2. submits a proper claim to the Claims Administrator before the benefits have been paid to the covered person or an assignee;

then the Claims Administrator may, with or without an assignment by the covered person, pay the benefits to the state department. To the extent of the payment, We will have no more liability under the group policy.

Exception for a Dependent Child Named in a Qualified Medical Child Support Order. We may pay benefits:

1. to a custodial parent or legal guardian if claim is made for reimbursement of benefits paid for a child named in a Qualified Medical Child Support Order;
2. directly to a provider if a custodial parent or legal guardian has made an assignment to the provider for such benefits.

Benefits Unpaid at Death; Incompetency. We may pay, to any person or institution that We find to be entitled to the payment, as much as \$500 of any benefits that:

1. are to be paid at the time of your death; or
2. are to be paid to a person who is a minor or who is not able to execute a valid release and for whom no guardian has been appointed.

To the extent of the payment, We will have no more liability under the group policy.

Physical Examination

We shall have the right and opportunity to have a covered person examined by a physician of its choice to determine the extent of any sickness or injury for which you have made a claim. This right may be used as often as it is reasonable to do so. Such an examination shall be made at Our expense.

Legal Action

No legal action can be started with respect to claims under the group policy:

1. until 60 days after the required proof of loss has been sent to the Claims Administrator; or
2. more than three years after the time proof of loss is required.

General Provisions

These General Provisions apply to all insurance under the group policy.

Assignment

You may assign the benefits to be paid under the group policy for a dental care charge. No other assignment of the group policy or any rights or benefits under the group policy will have any force or effect unless and until We consent to it in writing.

Incorrect Reporting

The facts reported by the Policyholder or by a covered person shall be used to determine to what extent, if at all, a covered person is or was insured under the group policy when:

1. any information that pertains to the covered person is found to have been reported incorrectly to Us or to the Claims Administrator, or if it is found that changes in such information are not reported to Us or to the Claims Administrator as required under the terms of the group policy; and
2. the information affects the existence or amount of, or premiums for, the insurance. In this event, a fair adjustment in the existence or amount of, or premiums for, the insurance shall be made.

Exemptions

To the full extent the law permits, all rights and benefits that accrue under the group policy shall be exempt from execution, attachment, or other legal process for the debts or liabilities of any covered person or beneficiary.

Workers' Compensation

The group policy is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

Entire Contract

The entire contract will be made up of: (1) the group policy; (2) the application of the Policyholder, a copy of which is attached to the group policy; and (3) the applications, if any, of the employees.

Statements Not Warranties

Life Insurance. All statements made by the Policyholder or by an insured employee will be deemed representations and not warranties. No statement made by the Policyholder or by the employee to obtain insurance will be used to avoid or reduce the insurance unless it is made in writing and is signed by the Policyholder or the employee and a copy is sent to the Policyholder, the employee, or his beneficiary.

Health Insurance. All statements made by the Policyholder or by an insured employee will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Policyholder or by the employee to obtain insurance will be used to avoid or reduce the insurance unless it is made in writing and is signed by the Policyholder or the employee and a copy is sent to the Policyholder, the employee, or his beneficiary.

Right to Contest

After the group policy has been in force for two years, We have no right to contest its validity except for nonpayment of premiums. We have no right to contest the insurance of an employee on the basis of any statement made by the employee after the employee's insurance has been in force for two years during his lifetime; and before then only if the statement was in writing on a form signed by the employee and a copy of it is given to the employee or his beneficiary. This provision, however, shall not preclude the assertion at any time of defenses based upon provisions in the group policy that relate to eligibility for insurance.