

FIRST HEALTH LIFE & HEALTH INSURANCE COMPANY

3200 Highland Avenue
Downers Grove, Illinois, 60515
(Herein We, Us and Our)

DENTAL EXPENSE COVERAGE

This is Your Certificate of Insurance (Certificate) while You are insured. It explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a contract between the Policyholder and Us.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in this Certificate. Benefit payment is governed by all the terms, conditions and limitations of the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment takes effect.

A copy of the Policy is kept at Our home office. You may inspect it during regular business hours.

This Certificate was issued on the basis that the information on Your application is correct and complete. **If any information on the application is not correct or complete, write to Us within ten (10) days of receipt of this Certificate. An error or omission may result in loss of coverage as of its effective date.**

Right to Examine: If You are not satisfied with this Certificate, return it to Our home office or to Your agent within [ten (10)] days after the date You received it. The Certificate will then be canceled and any Premium paid will be refunded.

Please Read this Certificate Carefully

TABLE OF CONTENTS

	Page		Page
<u>SCHEDULE</u> Certificate Number Insured Effective Date Covered Persons Initial Premium Premium Payable	[i]	<u>COST CONTAINMENT PROCEDURES</u> Pre-Determination <u>EXCLUSIONS AND LIMITATIONS</u> Pre-existing Condition Travel Outside U.S.	[9] [9]
<u>DEFINITIONS</u>	[2]	<u>PREMIUM PROVISIONS</u> Payment of Premium Due Date Returned or Dishonored Payment Grace Period Reinstatement Premium Adjustment	[12]
<u>CONDITIONS OF INSURANCE</u> Eligibility Effective Date	[4]	<u>CLAIMS PAYMENT PROVISIONS</u> Notice of Claim Claim Forms Proof of Loss Forgiveness of Deductible Payment of Claims Payment Error Fraudulent Claim Submission Appeal of Denied Claims	[13]
<u>TERMINATION DATE</u> Insured Dependent	[5]	<u>GENERAL PROVISIONS</u> Statements in the Application Misstatements of Age Clerical Error Legal Actions	[14]
<u>BENEFIT PROVISIONS</u> Deductible Insured Percent Maximum Benefit Amounts Covered Charges	[6]	<u>COORDINATION OF BENEFITS</u> Definitions Benefit Coordination Order of Benefit Determination Right to Exchange Information Right to Make Payments to Another Plan Right to Receive Payments <u>LIMITED RIGHT OF REIMBURSEMENT</u>	[15] [17]

DEFINITIONS

Covered Person: A person listed on the Schedule as insured under this Certificate.

Deductible: The amount of Covered Charges a Covered Person must pay before We pay any benefits.

Dependent: A person who is:

1. Your legally married spouse.
2. Your unmarried natural or legally adopted children who are dependent upon You for support and maintenance and are under the age of 19.
3. Your stepchildren who reside with You and are under the age of 19.
4. Your unmarried natural, step or legally adopted children age 19 to age 24, but only if they are:
 - a. Full-time students at an accredited educational institution; and
 - b. Dependent upon You for support and maintenance.

A child age 19 to age 24 ceases to be a Dependent on the last day of the month in which the child fails to qualify as a full-time student, except for regularly scheduled vacation periods. Dependents over the age of 24 will not cease to be a Dependent if he/she is handicapped, incapable of self-support and You declare the Dependent on Your income tax returns.

5. Your unmarried child for whom a court has issued a qualified medical child support order, which decrees that You must provide medical coverage.

Experimental/Investigational: A drug, device or medical treatment or procedure is considered experimental or investigational if:

1. It has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and law requires such approval;
2. Reliable evidence shows it is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis; or
3. Reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility or other facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical treatment or procedure.

However, a drug, device or medical treatment or procedure which has successfully completed a phase III clinical trial of the federal Food and Drug Administration for the illness or condition being treated, or for the diagnosis for which it is being prescribed, will not be considered experimental or investigational.

Dental Emergency: Any dental condition that results from an unforeseen circumstance and that requires immediate, urgent action to relieve pain, acute swelling or trauma.

Dental Injury: An injury to a sound natural tooth that occurs while a person is considered a Covered Person and that is caused by a sudden, violent external force that was not anticipated or that could not be avoided.

Family Member: You, Your spouse, or the parent, child, brother or sister of You or Your spouse.

Hospital: An institution licensed, accredited or certified by the State which: (a) is accredited by the Joint Commission on Accreditation of Hospitals; (b) provides 24-hour nursing service by registered nurses (RN); (c) mainly provides diagnostic and therapeutic care under the supervision of Physicians on an inpatient basis; and (d) maintains permanent surgical facilities.

A place, special ward, floor or other accommodation used for: custodial or educational care; rest; the aged; a nursing home; or an institution mainly rendering extended care or intermediate care will not be considered a Hospital.

Medically Necessary/Medical Necessity: A service, supply or drug that is necessary and appropriate for the diagnosis or treatment of a Sickness or a Dental Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to a confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A service, supply or drug shall not be considered as Medically Necessary if it:

1. Is Experimental, Investigational or furnished in connection with medical research;
2. Is provided solely for the convenience of the patient, the patient's family, Physician, Hospital or any other provider;
3. Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
4. Could have been omitted without adversely affecting the person's condition or the quality of medical care;
5. Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration; or
6. Involves a service, supply or drug not considered reasonable and necessary by the Health Care Financing Administration Medicare coverage issues manual.

We retain the right to determine whether a service, supply or drug is Medically Necessary.

Other Medical Expense Coverage: Any hospital or medical expense incurred policy or certificate, hospital or medical service plan and health maintenance organization subscriber contract, whether insured or uninsured, and regardless of where issued; or medical payments made pursuant to any national, state, or other governmental law of any country.

Physician: A licensed medical doctor; surgeon; osteopath; dentist; acting within the scope of such license, who is not a Family Member.

Pre-existing Condition: During the first [12] months prior to the effective date: (a) any Sickness or Dental Injury for which medical or dental care, treatment, diagnosis, or advice was received or recommended; or (b) the existence of any medical or dental symptoms which would cause an ordinary prudent person to seek medical or dental care, treatment, diagnosis or advice; to the extent that such care, treatment, diagnosis, advice or symptoms, in the absence of this definition, would have otherwise been considered covered dental expenses under this Certificate.

Sickness: Illness, disease, congenital defect, or birth abnormality.

Usual and Customary Charge: The lesser of: (a) the actual charge; (b) the fee most often charged by the provider for the same service or supply; or (c) the fee most often charged in the same area by providers with similar training and experience for a comparable service or supply. "Area" means a metropolitan area, a county or a greater area if needed to find a cross-section of providers of a comparable service or supply.

Year: The calendar period beginning each January 1 and ending the following December 31. The first Year shall begin on the Effective Date.

You or Your: The Insured named on the Schedule.

All male terms will include the female terms, unless stated otherwise.

CONDITIONS OF INSURANCE

A. ELIGIBILITY

1. INSURED - You are eligible for coverage when You complete a valid application and pay the Initial Premium.
2. DEPENDENT - A Dependent is eligible for coverage on the later of:
 - a. The date You become eligible for insurance; or
 - b. The date You acquire the Dependent.

A Dependent is deemed to be acquired as follows:

- i. **Spouse:** On the date of the marriage.
- ii. **Natural Child:** On the date of birth.
- iii. **Adopted Child:** On the date the child is placed in Your custody or the date You are legally or financially responsible for the child, if earlier.
- iv. **Step Child:** On the date the Insured marries the stepchild's natural parent.

B. EFFECTIVE DATE

1. INSURED - Coverage will start at 12:00 a.m. standard time at Your residence, on the Effective Date shown on the Schedule.
2. DEPENDENT
 - a. **Newborn:** Coverage for a newborn is effective from the moment of birth. For coverage to continue:

- i. We must receive written notice of the newborn within [45] days of the birth or before the end of the period for which Premium has been paid if later, and
- ii. You must pay any additional Premium within [31] days of receiving a notice of the amount due.

If notification of a newborn is received late, insurance will be effective only if an application for coverage is accepted by Us and Premium is paid.

- b. **Other Than A Newborn:** You must complete and sign an application, which includes Your Dependents. If accepted by Us, an Effective Date will be assigned as follows:
 - i. The date Your insurance is effective for Dependents eligible on that date and for whom coverage is applied
 - ii. For Dependents eligible on or first acquired after Your Effective Date; coverage will be effective on the date We assign.

TERMINATION DATE

A. INSURED

1. Coverage will terminate at 12:00 a.m. standard time at Your home on the earliest of:
 - a. The date coverage is terminated by Us for all certificate holders in Your state.
 - b. The date the Policy terminates.
 - c. The date We receive Your written request to have Your insurance terminated.
 - d. The end of the period for which Premium is paid, subject to the Grace Period.
 - e. The date of Your death.

At least [30] days prior written notice will be given to You if We terminate Your coverage for any reason, except for nonpayment of premium.

B. DEPENDENT

1. Dependent coverage will terminate at 12:00 a.m. standard time at Your home at the earliest of:
 - a. The premium due date following the date a Dependent ceases to be a Dependent as defined.
 - b. The end of the period for which Premium for Dependent coverage is paid.
 - c. The date Your coverage terminates, subject to any Continuation Of Coverage.
 - d. The date We receive Your written request to terminate Dependent coverage.

- e. The date the Dependent becomes eligible for Medicare.

BENEFIT PROVISIONS

Benefits are only payable for incurred Covered Charges that are Medically/Dentally Necessary and provided by or under the direction of a *dentist, dental hygienist or physician*.

After the Deductible, We will pay the Insured Percent for Covered Charges subject to:

1. The lesser of the Contracted Dental Rates for Network or Usual and Customary Charges for Non-Network as established by Us;
2. Definitions, limitations, exclusions, benefit maximums and other provisions of the Certificate; and
3. The Cost Containment Procedures.

A Covered Charge is considered incurred on the date the service is rendered or the supply is furnished.

A. DEDUCTIBLE

The Deductible applies separately to each Covered Person each Year. A separate Deductible must be met for a covered newborn child. The Individual Deductible is shown on the Schedule.

FAMILY MAXIMUM: All Covered Persons under this Certificate need only satisfy a set number of Deductibles each Year. Once that happens, any remaining Deductible amounts are considered satisfied for that Year. The Family Maximum Deductible is shown on the Schedule.

B. INSURED PERCENT

The Insured Percent is the portion of Covered Charges that We will pay after the Deductible has been met. The Insured Percent may vary for certain Covered Charges. The Insured Percents are shown on the Schedule.

C. MAXIMUM DENTAL BENEFITS

MAXIMUM DENTAL BENEFIT: The maximum amount that will be paid in a Calendar Year, under the Policy. The Maximum Dental Benefit is shown on the Schedule.

LIFETIME ORTHODONTIC MAXIMUM: The Lifetime Maximum is the maximum amount of benefits We will pay on behalf of any Covered Person over the lifetime of that person for orthodontic expenses.

SEPARATE BENEFIT MAXIMUM: Covered Charges for treatment of certain conditions may have additional limitations, as noted in the Covered Charges. Benefits paid pursuant to a Separate Benefit Maximum are included in the Maximum Dental Benefit.

D. COVERED CHARGES

When all of the provisions of this Certificate are satisfied, benefits will be provided as outlined on the Schedule for the services and supplies listed in this section.

Covered Preventive Services

- Periodic Oral examinations, limited to twice per calendar year.
- Prophylaxis (cleaning of the teeth), limited to twice per calendar year.
- Examinations for consultation purposes.
- Bitewing x-rays, limited to once per calendar year.
- Topical application of sodium or stannous fluoride, limited to once per calendar year.
- Application of sealants on posterior teeth (molars), limited to once per calendar year.

Covered Basic Services

- Periapical x-rays
- Occlusal x-rays, limited to once per calendar year.
- Full-mouth x-rays, limited to once every 3 calendar years.
- Panoramic x-rays, limited to once every 3 years, unless administered by a Specialist.
- Examination in connection with Dental Emergency palliative treatment.
- Lab tests (oral pathology).
- Injections of antibiotic or therapeutic drugs, in connection with another dental procedure.
- Application of desensitizing medications.
- Tooth extractions, simple and surgical, including routine postoperative care.
- Administration of general anesthesia and/or intravenous sedation, only when performed by an M.D. or Certified Registered Nurse Anesthetist (C.R.N.A.).
- Local anesthesia, including regional block anesthesia and injections, only if not in conjunction with operative or surgical procedures.
- Nitrous oxide.
- Oral surgery, limited to apicoectomy, alveoplasty, biopsies, osseous surgery and frenectomy.
- Amalgam, silicate, acrylic, synthetic porcelain, composite, plastic and sedative filling restorations to natural teeth for correction of decayed or fractured teeth, and/or defective materials.

- Adjusting, relining or rebasing of dentures after they have been installed for more than 12 months. Only 1 relining or rebasing is covered in a period of 12 months.
- Repair or recementing of crowns, inlays and onlays.
- Necessary repair or recementing of dentures or bridgework.
- The addition of teeth to an existing partial or removable denture.

Covered Major Services

- Endodontic treatment, including pulp capping, pulpotomy (deciduous teeth only) and root canal therapy.
- Treatment of periodontal disease, limited to periodontal maintenance prophylaxis, scaling/root planing, periodontal *surgery*, appliances and splinting. Includes all postoperative services and irrigation.
- Gold foil restorations.
- Inlays and onlays.
- Stainless steel crowns.
- Installation of permanent crowns.
- Installation of crowns, placement of post and core or crown buildup when there is demonstrable evidence of insufficient tooth structure to hold the crown.
- Temporary crowns.
- Necessary replacement of crowns, only when the crown is over 7 years old.
- Initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace extracted teeth.
- Temporary bridges.
- Pins and posts for bridgework and crowns.
- Stress breakers.
- Initial installation of dentures.
- Temporary partials and/or dentures.
- Overdentures.
- Replacement of an existing partial or full removable denture or fixed bridgework or bridgework to replace extracted teeth if satisfactory evidence is presented to the plan that:

The replacement or addition of teeth is necessary to replace teeth extracted after the existing denture or bridgework was installed.

The existing denture or bridgework cannot be made serviceable and was installed at least 7 years prior to the replacement date.

The existing denture is an immediate temporary denture replacing one or more extracted teeth, replacement by a permanent denture is required, and the replacement takes place within 6 months from the placement of the temporary denture.

Covered Orthodontic Services

Benefits as outlined on the Schedule for the services and supplies listed in this section for your dependents up to age 18.

- Necessary services related to an active course of orthodontic treatment.
- The initial and subsequent, if any, installation of orthodontic appliances for an active course of orthodontic treatment.
- The initial and subsequent, if any, installation of orthodontic appliances for an active course of orthodontic treatment, including retainers, cervical traction appliances and space maintainers.
- Adjustment of orthodontic appliances.
- Cephalometric x-rays.

COST CONTAINMENT PROCEDURES

B. PRE-DETERMINATION

If Predetermination is not completed, benefits will be reduced. The reduction is shown on the Schedule. Predetermination will be valid for 60 days.

How to Obtain a Predetermination: Call the telephone number on Your identification card. Be prepared to give the following information:

1. Insured's name, social security number and Certificate Number.
2. Patient's name and date of birth.
3. Provider name, address and telephone number.
4. The diagnosis (what is wrong).
5. The treatment (what will be done and when).

When to Call: For Covered Dental Expenses expected to exceed [\$200].

EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for any dental expenses arising from or in connection with:

- Treatment, services or supplies that are not specifically listed as Covered Charges.
- Treatment, services or supplies that are incurred when coverage is not in effect.
- Charges in excess of the Usual and Customary Charge.

- Treatment, services or supplies which:
 - a. Are not Medically Necessary or recognized by Us as effective;
 - b. Are not prescribed by a Physician as necessary to treat a Sickness or Dental Injury;
 - c. We determine to be Experimental or Investigational in nature;
 - d. Are received without charge or legal obligation to pay;
 - e. Would not routinely be paid in the absence of insurance;
 - f. Are received outside of the 50 United States and the District of Columbia, except as specifically stated; or
 - g. Are received while incarcerated by legal authorities of any state or country for any reason.

- Cosmetic surgery or procedures and related care or complications arising therefrom; except for specifically stated reconstructive surgery.

- Military or naval service of any country, except for military or naval service for 31 or fewer days.

- Any service, supply or treatment that does not meet the standards accepted by the American Dental Association (ADA).

- Services or supplies for which there is no legal obligation to pay, or charges that would not be made, except for the availability of benefits under the plan.

- Complications arising from any non-covered services or treatment, except as required by state law.

- Services furnished by or for the U.S. government or any other government, unless payment is legally required.

- Any condition, disability, or expense sustained as a result of being engaged in an illegal occupation or the commission or attempted commission of a felony.

- Any condition, disability, or expense sustained as a result of: duty as a member of the armed forces of any state or country; engaging in a war or act of war, whether declared or undeclared; participation in a riot or civil revolution ("Participation in a riot" means the Insured's intentional and willful actions designed to create and continue a violent public disorder. "Riot" means a violent public disorder by a group of persons acting with common intent.).

- Any condition or disability sustained as a result of being engaged in any activity primarily for wage, profit or gain, and that could entitle the covered person to a benefit under a workers' compensation act or similar legislation.

- Expenses for preparing or copying dental reports, itemized bills or claim forms.

- Mailing and/or shipping and handling charges.

- Sales tax.

- Expenses for broken appointments or telephone calls or telephone consultations.

- Travel expenses of a Physician or a covered person.

- Expenses incurred for services rendered prior to the date of coverage under this Certificate.

- Prescription drugs.
- Maxillofacial prosthetics.
- Appliances for the correction of harmful habits, such as grinding the teeth, thumb sucking, etc.
- Behavior management training, educational instruction and materials (including take-home supplies) relating to dietary counseling, personal oral hygiene or dental plaque control.
- Treatment, by any means, of jaw joint problems including temporomandibular joint dysfunction syndrome (TMJ) and other craniomandibular disorders, or other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues related to that joint.
- TMJ appliances.
- Myofunctional therapy.
- Veneers.
- Study models (unless for covered orthodontic treatment).
- Photos (unless for covered orthodontic treatment).
- Services and supplies for personalization or characterization of prosthetic devices.
- Duplicate prosthetic devices or appliances.
- Procedures or appliances to increase vertical dimension or restore occlusion, including analysis and guards.
- Athletic mouth guards.
- Hospital charges, except to the extent necessary to comply with state law.
- Expenses for services performed after the date coverage ends under this plan.

A. PRE-EXISTING CONDITION LIMITATION

Expenses that result from care or treatment of a Pre-existing Condition will not be considered as Covered Charges for the [12] months following the Covered Person's Effective Date of coverage.

B. TRAVEL OUTSIDE OF THE UNITED STATES

No benefits are payable for any medical care, treatment, services or supplies received outside of the United States, except for Dental Emergency treatment. Benefits are limited to Dental Emergency dental services that first occurs during the initial 60 days of travel. No dental benefits are payable for any treatment that occurs during travel for the 180 day period following the Effective Date of coverage for a Covered Person.

The term 'United States' means the 50 states and the District of Columbia. It does not include territories or possessions such as Puerto Rico or Guam.

PREMIUM PROVISIONS

A. PAYMENT OF PREMIUM

All premium, charges or fees (hereinafter "Premium") must be paid to Us at Our home office. All Premium is payable in advance.

We reserve the right to change the method of Premium payment selected with proper notice to You.

B. DUE DATE

The first Premium is due on the Effective Date of coverage. Subsequent Premium is due on the premium payment date shown on the Schedule. Failure to pay Premium when due shall result in termination of coverage on such due date subject to the Grace Period.

C. RETURNED OR DISHONORED PAYMENT

If a payment for any Premium is dishonored for insufficient funds, a reasonable service charge may be debited to You. A dishonored payment shall be considered a failure to pay Premium. A rejected debit to Your bank account or credit card shall be considered a failure to pay Premium.

If Your selected method of payment is dishonored as described, You will need to submit Premium in a method acceptable to Us prior to the end of the grace period.

D. GRACE PERIOD

If written notice of termination has not been received from You, a Grace Period of 31 days will be allowed for each Premium payment after the first Premium. If any Premium is unpaid at the end of the Grace Period, coverage shall automatically terminate on the last day for which Premium has been paid.

E. REINSTATEMENT

If coverage ends for failure to pay Premium, You may request a reinstatement. Such request must be in writing and submitted within [90 days] from the date coverage ended and is subject to Our approval. If approved by Us, reinstated coverage will become effective on the date We assign. Credit will be given for waiting periods satisfied prior to the date coverage ended.

F. PREMIUM ADJUSTMENT

Premium rates may be adjusted from time to time as determined necessary by Us. No rate adjustment will take effect until:

1. The end of any rate guarantee period; and
2. At least 31 days prior written notice is given to You.

The rate guarantee and notice period shall not apply to any rate adjustment due to:

1. Your request for a change in benefits or coverage;
2. A change in any Premium tax law;
3. A change in Federal or State law or regulation that affects the benefits or provisions of the Certificate;
4. A misstatement of age, sex, or residence of any Covered Person; or

5. A change in the residence of any Covered Person.

When coverage ends for a Covered Person, any resulting change in Premium will be made on the next premium Due Date.

A pro rata adjustment of Premium will be made if coverage ends due to Medicare eligibility.

CLAIMS PAYMENT PROVISIONS

A. NOTICE OF CLAIM

We must receive written notice of claim within 30 days after a covered loss starts or as soon thereafter as reasonably possible. Notice should include Your name and Certificate Number.

B. CLAIM FORMS

When We receive the notice of claim, We will send You forms for filing a Proof of Loss. If these forms are not sent to You within 15 days, You will meet the Proof of Loss requirement by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

C. PROOF OF LOSS

Written Proof of Loss must be completed and returned to Us within 90 days or as soon thereafter as reasonably possible. Except for absence of legal capacity, no claim for benefits will be accepted after one year from the date treatment was completed.

D. FORGIVENESS OF DEDUCTIBLE

If any provider intentionally does not collect (forgives) any Covered Charge amount, benefits payable will be recalculated as follows:

1. The amount accepted by the provider as payment in full will be considered the actual fee (i.e. the reported charge less any forgiven amount).
2. The adjusted charge will be reduced by the applicable Deductible.
3. The corresponding Insured Percent will be applied to the result.

Any resulting overpayment will be billed to You without prejudicing any other right or remedy available to Us at law or in equity.

E. PAYMENT OF CLAIMS

Benefits will be paid to You, unless assigned to the provider. In the case of a Dependent child in the legal custody of a person other than You, payment may be made directly to the custodian, at Our discretion or as required by law. Any unpaid Premium that is due may be deducted from a claim. Payment of benefits will discharge Us from all liability to You and Your beneficiary.

F. PAYMENT ERROR

Any benefit paid in error may be recovered from the person receiving the incorrect payment or from You. At Our option, We may offset the overpayment against future benefit payments. The acceptance of Premium or paying other benefits shall not constitute a waiver of Our rights under this section. Recovery or offset shall be in addition to any other remedies available to Us at law or in equity.

G. FRAUDULENT CLAIM SUBMISSION

If any Covered Person knowingly submits or participates in the submission of a claim for benefits that contains false or misleading information that would have the effect of increasing the benefit payable, We shall have the right to rescind that Covered Person's coverage to the date the fraud was perpetrated. Such rescission is without prejudice to any other right or remedy available to Us at law or in equity.

H. APPEAL OF DENIED CLAIMS

If a claim for benefits is wholly or partially denied, including a Pre-Determination of Benefits, You will be sent a written notice of the decision. This notice will:

1. Give the specific reason(s) for the denial;
2. Make specific reference to the provisions on which the denial is based; and
3. Provide an explanation of the review procedure.

On any denied claim, You or Your representative may appeal to Us for a full and fair review. You may:

1. Request a review in writing within 180 days of receipt of a claim denial; and
2. Submit issues and comments in writing.

We will make a decision no more than 60 days after receipt of the request. The written decision will include specific references to the provision(s) on which the decision is based.

GENERAL PROVISIONS

A. STATEMENTS IN THE APPLICATION

All statements made in Your application, in the absence of fraud, are considered to be representations and not warranties. No statement made by You shall be used to contest coverage or reduce benefits unless: (a) the statement is contained in an application; and (b) a copy of the statement is furnished to You.

After a Covered Person's coverage has been in effect for 2 years, during the lifetime of that person, no statements in the application may be used to void coverage or deny any claim.

B. MISSTATEMENT OF AGE

If the age of a Covered Person is misstated such that coverage is provided for which the person is not otherwise eligible at the correct age, the misapplied coverage shall be rescinded and any applicable Premium refunded.

If the age of a Covered Person is misstated such that the person is eligible for coverage at the correct age, premium will be adjusted. Any additional Premium due must be paid within 31 days of receiving a notice of the amount due.

C. CLERICAL ERROR

If a clerical error is made so that an otherwise eligible person's coverage does not become effective, coverage may be in effect if: (a) the person makes a written request for coverage on a form We approve; and (b) any premium not paid because of the error is paid in full from the effective date of coverage.

Company reserves the right to limit retroactive coverage to two months preceding the date the error was reported.

If a clerical error is made so that the coverage is in effect for a person who is not eligible, an adjustment will be made to correct the error. Any Premium refund will be reduced by any payment made for claims. If claims paid exceed the Premium refund, the Insured shall reimburse Company for the overpayment.

D. LEGAL ACTIONS

No legal action may be brought against Us within 60 days after written Proof of Loss has been sent to Us. No such action may be brought more than 3 years from the time written Proof of Loss is required to be given.

COORDINATION OF BENEFITS

A. DEFINITIONS

1. **Allowable Expense:** An expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.
2. **Coordination of Benefits:** Taking other Plans into account when We pay benefits.
3. **Plan:** Any plan, including this one that provides benefits or services for dental expenses on a group basis. "Plan" includes group and blanket insurance, self-insured and prepaid plans, and group or group-type coverage through Health Maintenance Organizations or Dental Maintenance Organizations and other prepayment, group practice and individual practice plans. It includes government plans, plans required or provided by statute (except Medicaid), and no fault insurance (when allowed by law). "Plan" shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or services of other plans and that part which does not.
4. **Primary Plan:** The Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Plans.
5. **Year:** The Calendar Year, or any part of it, during which a person claiming benefits is covered under this Plan.

B. BENEFIT COORDINATION

Benefits will be adjusted so that the total payment under all Plans is no more than 100 percent of the Covered Person's Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of coordination.

If a Covered Person's benefits paid under this Plan are reduced due to coordination, each benefit will be reduced proportionately. The amount of the reduction will be applied as a benefit credit to pay any portion of the Covered Person's Allowable Expense not covered by any Plan. This credit applies only to charges incurred during the same Year as the credit.

Only the amount of any benefit actually paid will be charged against any applicable benefit maximum.

C. THE ORDER OF BENEFIT DETERMINATION

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.
2. When a person is covered by a Plan without a coordination provision, the Plan without the provision will be the Primary Plan.
3. When a person is covered by more than one Plan with a coordination provision, the order of benefit payment is as follows:

- a. **Non-dependent/Dependent.** A Plan that covers a person other than as a Dependent will pay before a Plan that covers that person as a Dependent.
- b. **Dependent Child/Parents Not Separated or Divorced.** For a Dependent child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the Dependent child for the longer period will pay first.

If the other Plan uses gender to determine which Plan pays first, We will also use that basis.

- c. **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:
 - d. The Plan of the parent who has responsibility for providing insurance as determined by a court order;
 - e. The Plan of the parent with custody of the child;
 - f. The Plan of the spouse of the parent with custody; and
 - g. The Plan of the parent without custody of the child.

Dependent Child/Joint Custody. If the joint custody court decree does not specifically state which parent is responsible for the child's medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.

4. When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

D. RIGHT TO EXCHANGE INFORMATION

We may release to, or obtain from, any other insurance company, organization or person information necessary for coordination. This will not require the consent of, or notice to You or any claimant. You are required to give Us information necessary for coordination.

E. RIGHT TO MAKE PAYMENTS TO ANOTHER PLAN

Coordination may result in payments made by another Plan that should have been made by Us. We have the right to pay such other Plan all amounts it paid which would otherwise have been paid by Us. Amounts so paid will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

F. RIGHT TO RECEIVE PAYMENTS

Coordination may result in overpayments by Us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.

LIMITED RIGHT OF REIMBURSEMENT

If a Covered Person incurs medical expenses for Covered Charges that occurred due to the negligence of a third party, We will not provide any benefits unless and until the Covered Person, or his legal representative, agrees in writing:

1. To reimburse Us from any and all damages collected whether by action at law, settlement or otherwise, all benefits paid for the same medical expenses; and
2. To assign to Us, the right to recover from that third party, or its insurer, to the extent of the benefits paid under this Plan;

as permitted by law.