
Union Security Insurance Company agrees to provide the insurance described in this and the following pages of the *policy*, subject to payment of premiums.

Policyholder: Wisconsin Evangelical Lutheran Synod

Policy Number: G 5,298,449

Delivered In: Wisconsin and governed by its laws.

Effective Date: January 1, 2008 - The date the *policy* takes effect which is also its date of issue.

Premium Due Dates: The first premium is due on the Effective Date. Future premiums are due on the first day of each month after that.

Policy Anniversary: January 1, 2009, and each January 1 after that.

Insurance Provided: Group Dental Insurance – Contributory
Group Dental Insurance for Dependents – Contributory



Assistant Secretary



Executive Vice-President

Union Security Insurance Company 2323 Grand Boulevard Kansas City Missouri 64108-2670

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Union Security Insurance Company
Customer Relations
P.O. Box 419596
Kansas City, Missouri 64141-9958

800.442.7742

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by writing to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

or you can call 800.236.8517 outside of Madison or 266.0103 in Madison, and request a complaint form.

WISCONSIN HEALTH DISCLOSURE PROVISION

This policy limits covered dental expenses to the allowable charge amount for covered services. This amount may be less than the billed charge. Read your policy for definitions of "allowable charge".

If you need more information about the method used to determine the eligible amount of a dental insurance claim, please contact the Union Security Claims Benefit Center at 800.325.8385.

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GENERAL DEFINITIONS

These terms have the meanings shown here when *italicized*. The pronouns "we", "us", "our", "you", and "your" are not *italicized*.

Active work means working *full-time* for the *policyholder* or an *associated company* at your usual place of business.

Associated company means any company shown in the *policy* which is owned by or affiliated with the *policyholder*.

Contributory means you pay part or all of the premium.

Covered dependent means an *eligible dependent* who is insured under the *policy*.

Covered person means an eligible employee or member of the *policyholder*, or an *associated company* who has become insured for a coverage.

Doctor means a person, other than you, acting within the scope of his or her license to practice medicine and perform surgery.

Eligible class means a class of persons eligible for insurance under the *policy*. This class is based on employment or membership in a group.

Full-time means working at least 20 hours per week, unless indicated otherwise in the *policy*.

Home office means our office in Kansas City, Missouri.

Injury means accidental bodily injury. It does not mean intentionally self-inflicted injury while sane or insane.

No-fault motor vehicle coverage means a motor vehicle plan that pays disability or medical benefits without considering who was at fault in any accident that occurs.

Policy means the group policy issued by us to the *policyholder* that describes the benefits for which you may be eligible.

Policyholder means the entity to whom the *policy* is issued.

Proof of good health means evidence acceptable to us of the good health of a person.

We, us, and our mean Union Security Insurance Company.

You and your mean an eligible employee or member of the *policyholder* or an *associated company* who has become insured for a coverage.

DEFINITIONS FOR DENTAL INSURANCE

Accidental non-chewing injury means an *injury* (other than a chewing injury) sustained while insured under the *policy*, which is caused solely and exclusively by an accident which could not be predicted in advance, and which could not be avoided. A chewing injury is any *injury* which occurs during the act of biting or chewing, regardless of whether the *injury* is caused by biting or chewing food, biting on a foreign object not expected to be a normal constituent of food, parafunctional or abnormal habits such as (but not limited to) chewing on eyeglass frames or pencils, biting down on a suddenly dislodged or loose dental appliance, or biting or chewing on any other object for any other reason.

Allowable charge means:

- For a covered dental service rendered by a *preferred provider*, the *allowable charge* is based on an amount, as determined by us, that the *preferred provider* has agreed to accept.
- For a covered dental service rendered by a *non-preferred provider*, the *allowable charge* is the *reasonable charge*. The *reasonable charge* is the amount, as determined by us, accepted by providers in the area for like dental services. Our determination of what is an *allowable charge* or *reasonable charge* is final for the purposes of determining benefits payable under the *policy*.

Benefit year means a period of 12 consecutive months, which begins on the date you become insured under the *policy*. Subsequent *benefit years* begin on each succeeding anniversary of the date you became insured under the *policy*.

Continuous coverage/continuously covered means, with respect to a *transfer insured's* coverage under the *prior plan*, the most recent period of continuous coverage under the *prior plan* ending on the day before the effective date of this *policy*.

Copayment means the dollar amount you or a *covered dependent* pays to a *preferred provider* for *treatment*.

Dental hygienist means an individual who is licensed to practice dental hygiene and acting under the supervision of a *dentist* within the scope of that license in treating the dental condition.

Dental insurance means the group dental insurance under the *policy* issued by us to the *policyholder*.

Dentally necessary and dental necessity mean a service or *treatment* that is appropriate with the diagnosis and which is in accordance with accepted dental standards described in the American Dental Association Uniform Code on Dental Procedures and Nomenclature as determined by a dental professional selected by us. The service or *treatment* must be essential for the care of the teeth and supporting tissues.

Dental treatment plan means the *dentist's* report of recommended *treatment* which contains:

- a list of the charges and dental procedures required for the *dentally necessary* care;
- any supporting pre-operative x-rays; and
- any other appropriate diagnostic materials required by us.

Dentist means an individual who is licensed to practice dentistry and acting within the scope of that license in treating the dental condition.

Denturist means an individual who is licensed to make dentures and acting within the scope of that license in treating the dental condition.

DEFINITIONS FOR DENTAL INSURANCE (continued)

Emergency dental treatment means any *dentally necessary treatment* that is rendered as the direct result of unforeseen events or circumstances, which require prompt attention.

Family unit means you and your *covered dependents*.

Functioning natural tooth means a *natural tooth* which is performing its normal role in the chewing process in the person's upper or lower arch and which is opposed in the person's other arch by another *natural tooth* or prosthetic replacement.

Grievance means any dissatisfaction with the administration or claims practices of or provision of services under the *policy* which is expressed in writing by or on behalf of you or your *covered dependent*.

Immediate family means a person who is related to you or your spouse in any of the following ways: parent, spouse, child, brother, sister, or grandparent.

Medicare means a portion of Title XVIII of the United States Social Security Act of 1965, as amended.

Natural tooth means any tooth or part of a tooth that is organic and formed by the natural development of the body. Organic portions of the tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp.

Non-preferred provider means a *dentist, dental hygienist, dental office, medical center, or any dental care provider* who is not a participant in our *preferred provider plan* at the time covered dental services are provided.

Orthodontic treatment means the corrective movement of teeth through the bone by means of an active appliance to correct a handicapping malocclusion (a malocclusion severely interfering with a person's ability to chew food) of the mouth. We will make the determination of the severity of the malocclusion.

Other group dental expense coverage means:

- any other group policy providing benefits for dental expenses; or
- any plan providing dental expense benefits (whether through a dental services organization or other party providing prepaid health or related services) which is arranged through any employer or through direct contact with persons eligible for that plan.

Policy year means the period of time which begins on the *policy* anniversary date of each calendar year and ends on the day before the next following yearly *policy* anniversary date. The first *policy year* begins on the *policy* effective date. The last *policy year* ends on the day *dental insurance* under the *policy* ends.

Preferred provider means a *dentist, dental hygienist, dental office, or medical center or any dental care provider* who is a participant in our *preferred provider plan*.

Preferred provider plan means the dental care delivery system established by the plan manager in which *preferred providers* participate and under which we provide certain dental benefits.

Prior Plan means the policy(ies) or plan(s) providing dental care coverage to persons of the group, which is (are) replaced by insurance under our *policy* on the *policy* effective date.

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

Transfer insured means a person who both is insured under our *policy* on the *policy* effective date (without regard to the Exception to Effective Date provision) and was covered under the *prior plan* on the day just before that; but only so long as the person remains continuously insured under our *policy*. The

DEFINITIONS FOR DENTAL INSURANCE (continued)

Exception to Effective Date provision does not apply to such *transferred insureds*. The Continuance of Insurance provision applies to such *transferred insureds* that are not at *active work* on the *policy* effective date. However, the maximum continuation period will begin on the *policy* effective date.

Treatment means any dental consultation, service, supply, or procedure that is needed for the care of the teeth and supporting tissues.

SUMMARY OF GROUP INSURANCE

This summary is intended to help understand the group insurance policy. It does not change any of its provisions.

Dental Insurance

The *policy* pays benefits if a *covered person* or *covered dependent* incurs covered dental expenses as identified in the *policy*, subject to any applicable deductible amount. The Schedule of Benefits in the *policy*, lists the *copayment* amounts, deductible amounts and any applicable coinsurance percentages for the covered dental expenses. The Schedule of Benefits is a complete list of covered dental services. In addition, waiting periods may apply to some procedures.

If a *covered person* or *covered dependent* has more than one dental expense plan, benefits under the *policy* may be reduced so that all benefits received are not more than the actual expenses.

In the following pages, the provisions that describe a particular coverage were designed to be used in both the *policy* and the certificate. Therefore the terms “you” and “your” are used to refer to the *covered person*.

**Please read
the insurance
policy carefully**

ELIGIBILITY AND TERMINATION PROVISIONS

Eligible Persons

To be eligible for insurance, a person must:

- be a member of an *eligible class*; and
- complete any Service Requirement shown in the Schedule by continuous service with the employer, the *policyholder*, or an *associated company*.

The Present Service Requirement applies to persons in an *eligible class* on the Effective Date of the *policy*. The Future Service Requirement applies to persons who become members of an *eligible class* after that.

Effective Date for an Eligible Person

A person must apply for insurance on a form acceptable to us, and agree to pay part or all of the premium.

- If a person applies and we receive the application before becoming eligible, insurance will take effect on the Entry Date shown in the Schedule in the *policy*.
- If the application is made on the date the person becomes eligible, or within 31 days after that, insurance will take effect on the Entry Date occurring on or after the date of the application.
- If application is made more than 31 days after the day the person becomes eligible, or after insurance ended because the premium was not paid, then application must be made during an annual enrollment period. *Dental insurance* will then take effect on the policy anniversary occurring on or after the date of the application.

Exception to Effective Date

If an eligible person is not at *active work* on the day insurance would otherwise take effect, insurance will not take effect until the person returns to *active work*. If the day insurance would normally take effect is not a regular work day for a person, insurance will take effect on that day if the person is able to do his or her regular job.

When a Person's Insurance Ends

A *covered person's* insurance will end on the earliest of:

- the day the *policy* ends;
- the day the *policy* is changed to end the insurance for a person's *eligible class*;
- the last day of the month in which a person is no longer in an *eligible class*;
- the last day of the month in which a person stops *active work*;
- the day a required contribution was not paid; or
- the day a *covered person* becomes covered under an optional dental plan which is sponsored by the employer, or the *policyholder*, or an *associated company* and provided through a Dental Maintenance Organization.

ELIGIBILITY AND TERMINATION PROVISIONS (continued)

Continuance of Insurance

If a person is unable to perform *active work* for a reason shown below, the *policyholder* may continue the person's insurance and the person's dependent insurance, if any, on a premium-paying basis provided the person remains in other respects a member of the *eligible class*. The continuance cannot be more than the maximum continuance shown below. Continuance must be based on a uniform policy, and not individual selection.

The maximum continuance for *dental insurance* is the longest applicable period described below:

- 12 months* for *injury*, sickness, or pregnancy;
- 3 months* for lay-off, leave of absence (other than a family or medical leave of absence described below), or change to part-time; or
- the end of the period the *policyholder* is required to allow* for a family or medical leave of absence under:
 - the federal Family and Medical Leave Act; or
 - any similar state law.

* after the last day of *active work*.

Reinstatement

If a person re-enters an Eligible Class within 12 months after insurance ends, the person will not have to complete the Service Requirement again. All other provisions of the *policy* will apply.

ELIGIBILITY AND TERMINATION PROVISIONS FOR DEPENDENTS

Eligible Dependents

Your *eligible dependents* are:

- your lawful spouse, and
- your unmarried children who are less than age 19, or less than age 26 if a full-time student.

“Children” include any adopted children. A child will be considered adopted on the date of placement in your home. Stepchildren and foster children are also included if they depend on you for support and maintenance. “Children” also include any children for whom you are the legal guardian, who reside with you on a permanent basis and depend on you for support and maintenance.

An *eligible dependent* will not include any person who is a member of an *eligible class*. An *eligible dependent* may not be covered by more than 1 *covered person*.

Dependent Effective Date

You must apply for dependent insurance on a form acceptable to us. You must also agree to pay your share of the premium.

- If you apply before the dependent becomes eligible, dependent insurance will take effect on the Entry Date shown in the Schedule in the *policy*.
- If you apply on the date the dependent becomes eligible, or within 31 days after that, dependent insurance will take effect on the Entry Date occurring on or after the date of your application.
- If you apply more than 31 days after the date the dependent becomes eligible or after dependent insurance ended because the premium was not paid, then application must be made during an annual enrollment period. Dependent insurance will take effect on the policy anniversary occurring on or after the date of application.

Exception to Dependent Effective Date

Dependent insurance will not take effect until your insurance for the same coverage under the *policy* takes effect.

If an *eligible dependent* is in a hospital or similar facility on the day insurance would otherwise take effect, it will not take effect until the day after the *eligible dependent* leaves the hospital or similar facility. This exception does not apply to a child born while dependent insurance is in effect.

When Dependent Insurance Ends

A dependent's insurance will end on the earliest of:

- the day the *policy* ends;
- the day the *policy* is changed to end dependent insurance;
- the last day of the month in which that dependent is no longer eligible;
- the day your insurance for the same coverage under the *policy* ends;

ELIGIBILITY AND TERMINATION PROVISIONS FOR DEPENDENTS (continued)

- the day a required contribution for dependent insurance was not paid; or
- the day the dependent becomes covered under an optional dental plan which is sponsored by your employer, or the *policyholder*, or an *associated company* and provided through a Dental Maintenance Organization.

SPECIAL DEPENDENT INSURANCE CONTINUANCE PROVISIONS

As specified below, dependent *dental insurance* may continue, subject to the provisions that describe when insurance ends, and all other terms and conditions of the *policy*. Premiums are required for any coverage continued.

Physically Handicapped or Mentally Retarded Dependent Children

Dependent *dental insurance* for an *eligible dependent* child will continue beyond the date a child attains an age limit, if, on that date, he or she:

- is unable to earn a living because of physical handicap or mental retardation; and
- is chiefly dependent upon you for support and maintenance.

We must receive proof of the above within 120 days after the child attains the age limit and each year after that, beginning 2 years after the child attains the age limit. There will be no increase in premium for this continued coverage.

Dependent *dental insurance* will end when the child is able to earn a living or is no longer dependent on you for support and maintenance.

Students

Dependent *dental insurance* for an *eligible dependent* child will continue beyond the date the child is no longer a student until the earliest of:

- the end of the 3rd calendar month following the month in which the child is no longer a student;
- the child's 26th birthday; and
- the date the child becomes eligible for *other group dental expense coverage*.

SPECIAL FEDERAL CONTINUANCE PROVISIONS

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your *covered dependents* may have the right to continue *dental insurance* coverage beyond the date insurance would otherwise terminate. You should contact the *policyholder* concerning your right to continue coverage.

DENTAL INSURANCE

Insurance Provided

We will pay benefits for covered dental expenses identified in the *policy* when incurred by you or a *covered dependent*, while covered under the *policy*. Before we pay benefits, you or a *covered dependent*, as applicable, must satisfy any deductible required for the *policy year*. Benefits will be provided subject to all the terms and conditions of the *policy*.

For services performed by a *preferred provider* (other than Type IV Orthodontic Dental Services), you will be responsible for the *copayment* amount shown in the Schedule of Benefits. For Type IV Orthodontic Dental Services performed by a *preferred provider*, we will pay the coinsurance percentage shown in the Schedule of Benefits. For covered dental services performed by a *non-preferred provider*, including any Type IV Orthodontic Dental Services, we will pay the coinsurance percentage shown in the Schedule of Benefits. After we have paid any applicable coinsurance percentage for a covered dental expense, you will be responsible for any remaining charges.

Covered dental expenses will only include *treatment* provided to you or a *covered dependent* for which, as outlined in the Covered Dental Services provision, the date started and the date completed occur while the person is insured under the *policy*. No payment will be made for a program of dental *treatment* already in progress on the effective date of a person's insurance, except as stated in the Limited Benefits for Transferred Insureds' Services provision. No payment will be made for dental *treatment* completed after your or a *covered dependent's* insurance under the *policy* ends, except as stated in the Limited Extension of Benefits After Insurance Ends provision.

Preferred Provider Plan

This *policy* includes a *preferred provider plan*. We will provide the benefits of the *preferred provider plan*, as shown in the Schedule of Benefits, for covered expenses incurred by you or a *covered dependent* if the *treatment* is provided by a *preferred provider*. You or a *covered dependent* must be identified as being insured under the *preferred provider plan* each time *treatment* is received, to obtain the benefits of the *preferred provider plan*. We will provide the benefits of the *non-preferred provider plan*, as shown in the Schedule of Benefits, for covered dental expenses incurred by you or a *covered dependent* if the *treatment* is provided by a *non-preferred provider*.

You will receive a directory which lists the *preferred providers* who are participating in the *preferred provider plan*. Updated directories will be available every 6 months. You may call the toll-free number listed in the directory to verify whether or not a *preferred provider's* participation in the *preferred provider plan* has ended.

We reserve the right to terminate a *preferred provider* or the *preferred provider plan*. If we do terminate a *preferred provider* or the *preferred provider plan*, the benefit for a covered dental service will be the benefit payable for a covered dental service from a *non-preferred provider*.

Grievance Procedure

If you or your *covered dependent* have a *grievance*, you may contact us in writing. Within five business days of receipt of a *grievance*, we will deliver or deposit in the mail a written acknowledgement to you or your authorized representative confirming receipt of the *grievance*. We will resolve all *grievances* within 30 days after receipt of the *grievance*. If special conditions are involved and we are unable to resolve the *grievance* within the 30-day period, an extension of an additional 30 days will be allowed. You will be given a written explanation stating the reason for the extension and when resolution of the *grievance* can be expected. You may also write to us requesting to appear in person before a committee in order to present written or oral information concerning a *grievance*. We will inform you in writing of the time and place of the committee meeting at least 7 calendar days before the meeting.

DENTAL INSURANCE (continued)

The preceding paragraph will not apply to *grievances* related to situations requiring *emergency dental care*. We will resolve *grievances* related to *emergency dental care* within 72 hours of receiving notice of the *grievance*.

Deductible

The deductible is the amount shown in the Schedule of Benefits and will be applied to each type of dental services as indicated in the Schedule of Benefits. The deductible is the amount of covered dental expenses that you and each *covered dependent* must incur in a *policy year* before we will pay benefits. When covered dental expenses equal to the deductible amount have been incurred and submitted to us, the deductible will be satisfied. We will not pay benefits for covered dental expenses applied to the deductible.

If the deductible amount is increased during a *policy year*, further covered dental expenses must be incurred after the date of increase to satisfy the additional deductible for that *policy year*.

The deductible will apply to you and each *covered dependent* separately each *policy year*, except as stated in the Maximum Family Deductible section.

Maximum Family Deductible

The family deductible is shown in the Schedule of Benefits. It indicates the number of persons in your *family unit* who must each satisfy an individual deductible in order to satisfy the family deductible. Once that number of persons has satisfied a deductible for a *policy year*, we will consider the deductible to be satisfied for each person in your *family unit* for that *policy year*. We will pay benefits for covered dental expenses incurred on or after the date the required number of persons has satisfied the deductible amount. Expenses incurred for Type IV Orthodontic Dental Services will not be applied to the family deductible.

Policy Year Maximum

The maximum benefit payable to you or a *covered dependent* during a *policy year* is shown in the Schedule of Benefits. This maximum will apply even if coverage for you or a *covered dependent* ends and starts again within the same *policy year* or if you or a *covered dependent* have been covered both as an employee and a dependent.

Date Started and Date Completed

We consider a dental *treatment* to be started as follows:

- for a full or partial denture, the date the first impression is taken;
- for a fixed partial denture, crown, inlay and onlay, the date the teeth are first prepared;
- for root canal therapy, on the date the pulp chamber is first opened;
- for periodontal surgery, the date the surgery is performed; and
- for all other *treatment*, the date *treatment* is rendered.

We consider a dental *treatment* to be completed as follows:

- for a full or partial denture, the date a final completed appliance is first inserted in the mouth;
- for a fixed partial denture, crown, inlay and onlay, the date an appliance is cemented in place; and

DENTAL INSURANCE (continued)

- for root canal therapy, the date a canal is permanently filled.

(See Type IV: Orthodontic Dental Services for start and completion dates for *orthodontic treatment*.)

Pre-estimate

Whenever the expected cost of a *treatment* exceeds \$300, we recommend that a *dental treatment plan* be submitted to us for review before *treatment* begins. The *dental treatment plan* should be accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials as requested by us. We will notify you and your *dentist* of the benefits payable based upon the *dental treatment plan*. In estimating the amount of benefits payable, consideration will be given to the least costly alternative procedures and materials that may accomplish a result that meets broadly accepted standards of professional dental care as determined by us.

If a *dental treatment plan* is not completed within six months of the pre-estimate, we may consider it invalid. We may request the submission of a new *dental treatment plan*.

If you and your *dentist* decide on a more costly method of *treatment* than that pre-estimated by us, benefits payable for covered dental services for the more costly *treatment* may be limited to the benefits that would have been payable for covered dental services for the least costly alternative *treatment*. We will not pay the excess amount. Since this may result in significant out-of-pocket expense, we strongly encourage you to receive a pre-estimate for any *dental treatment plan* that is expected to exceed \$300 in cost.

In addition to a *dental treatment plan*, before *orthodontic treatment* begins we may request any of the following information to help determine benefits payable for orthodontic services:

- full mouth dental X-rays;
- cephalometric X-rays and analysis;
- diagnostic casts (study models); and
- a statement specifying:
 - degree of overjet, overbite, crowding and open bite;
 - whether teeth are impacted, in crossbite, or congenitally missing;
 - length of *orthodontic treatment*; and
 - total *orthodontic treatment* charge.

Alternative Benefits

In determining the benefits payable on a claim, we may consider other alternative procedures and materials that can be used to treat a dental problem or disease. The covered dental expense for a covered dental service provided may be limited to the *allowable charge* for the least costly covered dental service that accomplishes a result which meets broadly accepted standards of professional dental care as determined by us. You and your *dentist* may decide on a more costly procedure or material than we have determined to be satisfactory for the *treatment* of the dental problem or disease. In this event, we may not pay the excess amount. The benefit payable may be limited to the benefit that would have been payable had the least costly covered dental service been provided instead.

Covered Dental Expenses

Covered dental expenses for *treatment* performed by a *preferred provider* will include only the amount agreed upon by the *preferred provider* under the *preferred provider plan*.

DENTAL INSURANCE (continued)

Covered dental expenses for *treatment* performed by a *non-preferred provider* will include only the lesser of the *dentist's* actual charge or the *allowable charge* for expenses incurred by you or a *covered dependent*.

The *treatment* for all covered dental expenses must be:

- performed by or under the direction of a *dentist*, or performed by a *dental hygienist* or *denturist*,
- *dentally necessary*; and
- started and completed while you or your *covered dependent* are insured, except as otherwise provided in the Limited Benefits for Transfer Insureds' Services Started Under Prior Plan and Limited Extension of Benefits After Insurance Ends provisions.

Expenses submitted to us must identify the *treatment* performed in terms of the American Dental Association Code on Dental Procedures and Nomenclature. We reserve the right to request X-rays, narratives and other diagnostic information, as we see fit, to determine benefits.

We will only pay benefits for covered dental expenses incurred for *treatment* that, in our opinion, has a reasonably favorable prognosis for the patient.

We consider a temporary *treatment* to be an integral part of the final *treatment*. The sum of the fees for temporary and final *treatment* will be used to determine whether the charges are an *allowable charge*.

Covered Dental Services

Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the Schedule of Benefits. However, benefits will be payable based on the most current dental terminology.

Type I, II and III Dental Services

For all Type I, II, and III Dental Services, the Schedule of Benefits is the complete list of covered dental services. The Schedule of Benefits may be updated periodically upon written notice.

We will not pay benefits for expenses incurred for any service not listed in the Schedule of Benefits, unless we agree to accept an unlisted service as a covered dental service. We will not accept any unlisted service which is not similar to, or which does not accomplish a result similar to, a listed service. In any event, the choice of whether or not to accept an unlisted service is solely ours. If we do accept an unlisted service as a covered dental service, benefits will be payable on a basis consistent with benefits for similar covered dental services which would provide the least costly adequate *treatment* of your or your *covered dependent's* dental condition according to broadly accepted standards of professional dental care as determined by us.

Frequency limitations and other limits are shown in the Schedule of Benefits and under Special Limitations and General Exclusions for certain services. Services performed outside these limits are not covered dental services.

Type IV Orthodontic Dental Services

The following is a complete list of covered Orthodontic Dental Services:

- Limited Orthodontic Treatment
- Interceptive Orthodontic Treatment

DENTAL INSURANCE (continued)

- Comprehensive Orthodontic Treatment
- Minor Treatment To Control Harmful Habits

Covered dental expenses for *orthodontic treatment* are subject to the following:

A covered dental expense for a covered dental service for *orthodontic treatment* is the lesser of the provider's actual fee or the *allowable charge*. A covered dental expense for orthodontic exposure or extraction of teeth is deemed incurred on the date the service is completed and benefits are payable based on that date as stated in this provision. Covered dental expenses for orthodontic evaluation and *orthodontic treatment* are deemed incurred on a monthly basis beginning with the date *orthodontic treatment* is started and continuing throughout the course of *orthodontic treatment* according to the rules stated in this provision.

Covered Dental Expenses for *orthodontic treatment*, do not include, and we will not pay orthodontic expenses for, orthodontic evaluation or exposure or extraction of teeth which is not an essential preliminary (as determined by us) to *orthodontic treatment* which is actually performed. Only the services listed above will be considered to be covered dental services for *orthodontic treatment*. The services will only be covered if they are:

- essential, as determined by us, to correct a *covered dependent* child's handicapping malocclusion (or as an essential preliminary to such correction, as determined by us); and
- the *covered dependent* child is under age 19 years on the date the *orthodontic treatment* is started.

Upon our receipt of proof that covered dental expenses have been incurred for covered dental services for exposure or extraction of teeth prior to and in connection with *orthodontic treatment* for a *covered dependent* child who is insured for orthodontic expense benefits (and who is under age 19 years on the date that *orthodontic treatment* is started), we will calculate and pay benefits as follows:

- a) Determine the lesser of the dentist's actual fee or the *allowable charge* for each such service completed. The result, subject to all other *policy* provisions, is the covered dental expense for that service.
- b) Determine the coinsurance percentage for each such covered dental expense.
- c) Total all such coinsurance percentage to obtain the benefit for the submitted claim, subject to the Overall Benefit Maximum for Type IV Dental Services and all other *policy* provisions.

Upon our receipt of proof that covered dental expenses have been incurred for covered dental services for *orthodontic treatment* and any evaluation prior to and in connection with that *treatment* for a *covered dependent* child who is insured for orthodontic expense benefits (and who is under age 19 years on the date that *orthodontic treatment* is started), we will calculate and pay monthly benefits as follows:

- a) Determine the lesser of the *dentist's* actual fee or the *allowable charge* for each covered dental service for the entire planned course of *orthodontic treatment* which has started and for each covered dental service for evaluation which was completed prior to and in connection with that *orthodontic treatment*. Add the results.
- b) Determine 50% of the resulting total.
- c) Determine the lesser of that amount or the available Overall Benefit Maximum for Orthodontic Services remaining.

DENTAL INSURANCE (continued)

- d) If the *dentist* did not make a separate charge for initial insertion of the first orthodontic appliance(s), divide the result in (c) by one more than the total number of months in the entire planned course of an *orthodontic treatment* to get a monthly benefit amount (the same amount for the initial and each subsequent monthly benefit).
- e) If the *dentist* did make a separate charge for initial insertion of the first orthodontic appliance(s), determine 25% of the result in (c) to get an initial monthly benefit amount. Divide the remaining 75% of the result in (c) by the total number of months in the entire planned course of *orthodontic treatment* to get a subsequent monthly benefit amount.
- f) The initial monthly benefit is payable on the date the *orthodontic treatment* is started. A subsequent monthly benefit is payable on the date each month of ongoing *treatment* is completed in that planned course of *orthodontic treatment*, but only if both: (1) the month of ongoing *treatment* is a covered dental service; and (2) we receive proof that *treatment* continued during that month.
- g) All monthly benefits otherwise payable as stated above are subject to the Overall Benefit Maximum for Type IV Services and all other *policy* provisions.

If the *dentist* deliberately does not collect (that is, forgives) some or all of the amounts due from you, we will recalculate the benefits payable according to the above rules; but we will use the amount which the *dentist* accepted as payment in full (that is, the original fee less the amounts forgiven) as the charge actually made by the provider. You will then owe us the amount of any overpayment we may have made.

The *Policy Year* Maximum does not apply to benefits payable for covered dental expenses for orthodontics. Instead, the Overall Benefit Maximum for Type IV Services shown in the Schedule of Benefits applies to benefits payable for such expenses. The Overall Benefit Maximum for Type IV Services is the limit on the total amount of benefits payable for covered dental expenses incurred for a *covered dependent* child's covered dental services for *orthodontic treatment* in his lifetime. A single Overall Benefit Maximum for Type IV Services applies to a child even if his insurance has been interrupted or he has been insured both as a *covered person* and as a *covered dependent*.

The Waiting Period for orthodontic dental services is shown in the Schedule of Benefits, and starts on the later of: (a) the *policy* effective date; or (b) the *covered dependent* child's effective date of insurance (most recent effective date if previously insured). If the date started for *orthodontic treatment* is before the waiting period ends, the entire course of *orthodontic treatment* is excluded from being a covered dental service. If the date started for any other dental service for *orthodontic treatment* is before the Waiting Period ends, the service is excluded from being a covered dental service.

Orthodontic treatment is deemed started on the date the first active orthodontic appliance is first inserted. Each month of ongoing *orthodontic treatment* following that date is deemed completed on the monthly anniversary of that date in each following calendar month. (For *orthodontic treatment* deemed started on the last day of a calendar month, the monthly anniversaries are deemed to be the last day of each following calendar month.) A covered dental service for orthodontic evaluation or exposure or extraction of teeth will be considered started and completed on the date that the service is actually performed.

The entire course of *orthodontic treatment*, and any preliminary orthodontic evaluation or exposure or extraction of teeth, are excluded from being covered dental services (and no benefits are payable) if the date started for the *orthodontic treatment* is on or after the date your *covered dependent* child reaches age 19 years.

The entire course of *orthodontic treatment* is excluded from being a covered dental service (and no benefits are payable) if the date started is before any of the following dates: (a) the effective date of this *policy*; or (b) the effective date of the *covered dependent's* insurance (most recent effective date if previously insured); or (c) the end of the waiting period.

DENTAL INSURANCE (continued)

Special Limitations

Waiting Periods for Insured Persons Generally

You and your *covered dependents* must serve a waiting period for one or more Types of Dental Services. A waiting period is a stated period of time starting on the effective date of your or a *covered dependent's* insurance. ("Effective date" means the most recent effective date of *dental insurance* if you or a *covered dependent* were previously insured.) If the date started for a service is before the applicable waiting period ends, the service is excluded from being a covered dental service. The Types of Dental Services with waiting periods and the lengths of such waiting periods are shown in the Schedule of Benefits.

Restorative Services

Covered Dental Expenses and covered dental services do not include, and we will not pay benefits for, the following:

- Inlays, onlays, crowns, cast restorations, or other laboratory prepared restorations:
 - on teeth which may be restored with a direct placement filling material;
 - in the absence of extensive decay or fracture;
 - for loss of tooth structure due to attrition or abrasion; or
 - for children under age 16 years, except for prefabricated stainless steel or prefabricated resin crowns on deciduous or primary teeth.
- The initial placement of a complete or partial denture unless:
 - it includes the replacement of a *functioning natural tooth* extracted while you or your *covered dependent* are insured under the *policy*; and
 - that tooth cannot be added to an existing partial denture. We will not pay benefits for the initial placement of a complete or partial denture which replaces only those *natural teeth* missing on the date your or your *covered dependents'* insurance begins.
- The initial placement of a fixed partial denture unless:
 - it includes the replacement of a *functioning natural tooth* extracted while insured under the *policy*; and
 - that tooth was not an abutment to an existing fixed partial denture that is less than 10 years old. Benefits for such initial placement are limited to benefits for the replacement of those *functioning natural teeth* which were extracted while you or your *covered dependent* are insured under the *policy* and were not abutments to an existing fixed partial denture less than 10 years old. We will not pay benefits to replace *natural teeth* missing on the date that your or your *covered dependent's* insurance begins.
- The replacement of inlays, onlays, crowns, cast restorations, or other laboratory prepared restorations unless:
 - at least 10 years have passed since the last placement (36 months for prefabricated stainless steel or prefabricated resin crowns); and
 - they are not serviceable and cannot be restored to function.

DENTAL INSURANCE (continued)

- The replacement of a complete or partial denture, or the addition of teeth to a partial denture, unless:
 - replacement occurs at least 10 years after the initial date of insertion of the existing denture, provided the existing denture is not serviceable and cannot be restored to function; or
 - the addition of a tooth to a partial denture is required due to the *dentally necessary* extraction of a *functioning natural tooth* while you or your *covered dependent* are insured under the *policy*, or
 - the replacement is made *dentally necessary* by an *accidental non-chewing injury* to a *sound natural tooth*, provided the replacement is completed within 12 months of the injury.
- The replacement of a fixed partial denture unless:
 - replacement occurs at least 10 years after the initial date of insertion of the existing fixed partial denture, provided the existing fixed partial denture is not serviceable and cannot be restored to function; or
 - replacement is required due to the *dentally necessary* extraction of a *functioning natural tooth* while *you or your covered dependent* are insured under the *policy*, *provided* that the extracted tooth was not serving as an abutment to the existing fixed partial denture; or
 - replacement is made, provided the replacement is made *dentally necessary* by an *accidental non-chewing injury* to a *sound natural tooth*, and is completed within 12 months of the injury.
- The replacement of an existing partial denture with fixed partial denture work unless upgrading to fixed partial denture work is essential, as determined by us, to the correction of *your or your covered dependent's* dental condition.
- The replacement of teeth beyond the normal complement.
- Appliances, inlays, onlays, crowns, or other cast or laboratory prepared restorations used primarily for the purpose of splinting.
- Facings on crowns or fixed partial dentures on molar teeth (which are always considered cosmetic under the *policy*).

Coverage Under the Group's Medical Plan

If benefits for any covered dental expenses are provided under your employer's medical plan (if any), benefits otherwise payable for those expenses under the *policy* will be reduced by the amount of benefits payable for those expenses under your employer's medical plan.

General Exclusions

Covered dental expenses and covered dental services do not include, and we will not pay benefits for, the following:

- *treatment* which:
 - is not included in the Schedule of Benefits; or

DENTAL INSURANCE (continued)

- has a date started before your or a *covered dependent's* insurance begins; or
- has a date started before any applicable Waiting Period has been served; or
- has a date completed after your or a *covered dependent's* insurance ends, except as may be specifically provided under Limited Extension of Benefits After Insurance Ends.
- any *treatment*, the sole or primary purpose of which relates to:
 - the change or maintenance of vertical dimension; or
 - the alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service); or
 - bite registration; or
 - bite analysis.
- athletic mouthguards; replacement of lost or stolen appliances; myofunctional therapy; infection control; oral hygiene instruction; separate charges for acid etch; treatment of jaw fractures; orthognathic surgery; personal supplies; broken appointments; completion of claim forms; exams required by a third party; travel time; transportation costs; professional advice given on the phone.
- *treatment* which:
 - is not *dentally necessary*; or
 - does not have uniform professional endorsement.
- *treatment* which does not have a reasonably favorable prognosis, based on standards described in the American Dental Association Uniform Code on Dental Procedures and Nomenclature as determined by a dental professional selected by us.
- *treatment* provided primarily for cosmetic purposes.
- *treatment* received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit an assault or felony.
- *treatment* of *injury* arising out of, or in the course of, doing any work for pay, profit, or gain, whether on your or a *covered dependent's* job or any other job.
- *treatment* of an intentionally self-inflicted injury.
- *treatment* performed outside of the United States of America, other than *emergency dental treatment*. However, for such *emergency dental treatment*, the benefits payable shall not exceed the *allowable charge* for the *treatment* at your employer's principal address (shown in the application for insurance) in the USA.
- *treatment* rendered by a dental clinic or similar clinic that is operated by your or your spouse's employer, labor union, or similar group.
- *treatment* of a provider who is a member of your or your spouse's *immediate family*.

DENTAL INSURANCE (continued)

- *treatment* for which a charge would not have been made in the absence of insurance.
- *treatment* for which you or your *covered dependent* do not have to pay, except when payment of such benefits is required by law and only to the extent required by law.
- *treatment* that has not been both delivered to and accepted by you or your *covered dependent*.
- *orthodontic treatment*, unless such insurance is provided under the Type IV Orthodontic Dental Services provision.

Limited Extension of Benefits After Insurance Ends

If an otherwise non-orthodontic covered dental service is started while you or your *covered dependent* are insured under the *policy* (and after any applicable waiting periods are served), but is completed after the day your or your *covered dependent's* insurance ends, we will pay benefits for otherwise covered dental expenses incurred for that service subject to all of the following rules:

- Benefits are not available to you or your *covered dependent* if, on the day after insurance ends, you or your *covered dependent*, obtain, or are eligible to obtain, dental care coverage under any group or governmental plan;
- Benefits are not available to you or your *covered dependent* if insurance ends because any required premium contributions were stopped while still eligible for insurance;
- Benefits are not available for any *treatment* started after the day your or your *covered dependent's* insurance ends;
- Benefits are payable only in the amount that would have been payable, and subject to the same provisions that would have applied, had your or your *covered dependent's* insurance still been in effect;
- Benefits are payable only if the *treatment* is completed within 31 days after the date your or your *covered dependent's* insurance ends, unless you or your *covered dependent* become injured or sick after the *treatment* is started and that is the only reason the *treatment* could not be completed during those 31 days. Then, benefits are payable only if the *treatment* is completed before the earlier of:
 - the date 31 days after the first date the *injury* or sickness no longer prevents the *treatment* from being completed; or
 - the date 91 days after the date your or your *covered dependent's* insurance ends;
- We will not pay any benefits for *treatment* which is completed on or after the first date you or your *covered dependent* obtain, or are eligible to obtain dental care coverage under any group or governmental plan.

Limited Extension of Orthodontic Benefits After Insurance Ends

Any month of ongoing *orthodontic treatment* which has a date completed after the earliest of the following dates is excluded from being a covered dental service (and no benefits are payable for that month of *orthodontic treatment*):

DENTAL INSURANCE (continued)

- the day before the *policy* is amended to exclude *orthodontic treatment* from the coverage provided to *covered dependent* children of the class of employees to which you belong; or
- the date the *covered dependent's* insurance ends.

NOTE: We will make one exception to this exclusion. If a month of ongoing *orthodontic treatment* has a date completed after the earlier of the above dates, but that month of *orthodontic treatment* began while both this coverage under the *policy* and the *covered dependent's* insurance were in effect, we will pay a benefit for that month of *orthodontic treatment* in the same amount, and subject to the same *policy* provisions, that would have applied if both this coverage and the *covered dependent's* insurance were still in effect.

Limited Benefits for Transfer Insureds' Services Started Under Prior Plan

Our *policy* excludes benefits for services started before the date your or your *covered dependent's* insurance under our *policy* begins. However, if you or your *covered dependent* are a *transfer insured*, we will calculate and pay limited benefits as follows for otherwise-covered dental expenses for services started while you or your *covered dependent* were *continuously covered* under the *prior plan*, but completed while you or your *covered dependent* are insured under our *policy*.

1. Determine the amount (if any) that would have been payable had the service been started and completed while you or your *covered dependent* were *continuously covered* under the *prior plan*.
2. Determine the amount (if any) that would have been payable had the service been started and completed while you or your *covered dependent* were insured under our *policy*.
3. If either amount is zero, there is no benefit payable under this provision.
4. If both amounts are nonzero, we will prorate the lesser of the two amounts according to our established proration schedule to determine a prorated benefit for each part of the service performed.

We will pay a prorated benefit only for that part of the service that is performed:

- a) while you or your *covered dependent* are insured under our *policy*, and
- b) after the end of any period during which the *prior plan* extends benefits for the service.

We will not pay any benefit for any part of the service that is performed either:

- a) before you or your *covered dependent* are insured under our *policy*, or
- b) in any period during which the *prior plan* extends benefits for the service.

Transfer Insureds' Orthodontic Services Started Under Prior Plan

The above calculation for benefits payable for Transfer Insureds' Services Started Under the Prior Plan does not apply to dental services for *orthodontic treatment*. The *policy* excludes benefits for *orthodontic treatment* started before the *covered dependent child's* insurance under our *policy* begins. However, if the *covered dependent* child is a *transfer insured*, we will calculate and pay limited benefits as follows for otherwise-covered dental expenses for *orthodontic treatment* which started while the *covered dependent* child was *continuously covered* under the *prior plan* and is still ongoing when the *covered dependent* child's insurance under our *policy* begins:

1. We must receive proof that benefits were paid and are payable under the *prior plan* for that *orthodontic treatment*, and that the total of such benefits for:

DENTAL INSURANCE (continued)

- a) that ongoing orthodontic treatment; plus
- b) any evaluation prior to and in connection with the *orthodontic treatment*; plus
- c) any exposure or extraction of teeth prior to and in connection with the *orthodontic treatment*;

is less than the amount of the Overall Benefit Maximum for Type IV Services under our *policy*.

If we do not receive such proof, no benefit is payable under this provision.

2. If we receive such proof, we will determine whether or not benefits would have been provided had that ongoing *orthodontic treatment* been started while the *covered dependent* child was insured under our *policy* (without regard to any Waiting Periods that might otherwise apply). If no such benefits would have been provided, no benefit is payable under this provision.
3. We will calculate the portion of the Overall Benefit Maximum available for that ongoing *orthodontic treatment* under our *policy* as being the lesser of:
 - a) the Overall Benefit Maximum for Type IV Services under our *policy*; or
 - b) any overall benefit maximum for orthodontics under the *prior plan*; reduced by the total orthodontic benefits paid or payable under the *prior plan* as described in (1) above.
4. We will calculate a monthly benefit for that ongoing *orthodontic treatment* using the rules in the Type IV Dental Services provision, but with the reduced Overall Benefit Maximum as described in (3) above replacing the Overall Benefit Maximum for Type IV Services under our *policy* in that calculation.
5. The monthly benefit described in (4) above will be payable on the date each month of treatment is completed in the planned course of treatment, but only if:
 - a) that month of treatment begins while the *covered dependent* child is insured under our *policy*; and
 - b) that month of treatment would have been a covered dental service under our *policy* had the *orthodontic treatment* started while the *covered dependent* child was insured under our *policy* (without regard to any Waiting Periods that might otherwise apply); and
 - c) we receive proof that *orthodontic treatment* continued during that month.

All monthly benefits otherwise payable as stated in (5) above are subject to the reduced Overall Benefit Maximum as described in (3) above and all other provisions of the *policy*.

Transfer Insureds' Teeth Extracted Under Prior Plan

Under Restorative Services in the Special Limitations provision, items pertain to complete and partial dentures and fixed partial dentures. These items all have references to missing *natural teeth* or to *functioning natural teeth* that have been extracted. For the purpose of applying these limitations where you or your *covered dependent* are a *transfer insured*, a *functioning natural tooth* which was extracted while you or your *covered dependent* were *continuously covered* under the *prior plan*, but no earlier than 12 months before the effective date of this *policy*, will be deemed to have been extracted while insured under this *policy*.

Credit Given To Transfer Insureds For Waiting Periods

In the DENTAL INSURANCE section under Waiting Periods for Insured Persons Generally, our *policy* provides in general that you and your *covered dependents* must serve a Waiting Period for certain Type

DENTAL INSURANCE (continued)

III Dental Services. The Types of Dental Services with waiting periods are shown in the Schedule of Benefits, together with the lengths of such waiting periods in months. On the *policy* effective date, each *transfer insured* is deemed to have served 12 months of each such waiting period (or the whole waiting period, if it is less than or equal to 12 months)—but only with regard to Types of Dental Services shown in the Schedule of Benefits.

Transfer Insureds' Waiting Period for Type IV Services

The above credit for time served toward a Waiting Period applies only to the Waiting Periods for Type III Dental Services, if applicable, and not to Type IV Dental Services for *orthodontic treatment*. Under the Waiting Period provision in the Schedule of Benefits, there is a Waiting Period for Type IV Dental Services for *orthodontic treatment*. On the *policy* effective date, each *transfer insured* is deemed to have served 12 months of that Waiting Period (or the whole Waiting Period), if it is less than or equal to 12 months.

COORDINATION OF BENEFITS

Applicability

All of the benefits provided under the *policy* are subject to *this provision*.

Definitions

Allowable expense means any *dentally necessary, allowable charge*, at least a portion of which is covered under 1 or more of the *plans* which covers the person:

- for whom claim is made, and
- on whose account payment is legally required.

When a *plan* provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be both an *allowable expense* and a benefit paid.

When benefits are reduced because the person does not comply with the provisions of a plan, the amount of the reduction will not be considered an *allowable expense*. However, any services rendered by a non-HMO/DMO provider for which the HMO/DMO denies payment will be considered an *allowable expense*.

Claim period means a *policy year*. A *claim period* will not start before a person's effective date of insurance under *this plan* nor extend beyond the last day the person is covered under *this plan*.

Medicaid means Title XIX of the Social Security Act of 1965 as amended.

Plan means any plan which provides benefits or services for medical or dental care or *treatment* through:

- group, blanket, or franchise insurance coverage;
- group hospital, medical, or dental service prepayment coverage, group or individual practice or other group prepayment coverage, or group-type coverage through Health Maintenance Organizations (HMOs) or Dental Maintenance Organizations (DMOs);
- a labor-management trustee plan, union welfare plan, employer or employee organization plan or any other arrangement of benefits, not available to the general public, which is based on membership in a group;
- coverage under government programs or coverage required or provided by any statute, except *Medicaid*. Benefits and services provided by Part A and Part B of *Medicare* are included. If you or a *covered dependent* are eligible for, but not covered under both Part A and Part B of *Medicare* for any reason, the benefits or services that would have been payable if you or the *covered dependent* had been covered, will be included, unless prohibited by state law or regulation; or
- *no-fault motor vehicle coverage* or a Motor Vehicle Financial Responsibility Act, unless prohibited by state law or regulation.

Plan does not include any of the following:

- *school accident coverage*;
- the first \$100 per day of benefits under a group or group-type hospital indemnity benefit, written on a non-expense incurred basis;

COORDINATION OF BENEFITS (continued)

- *Medicaid*; and does not include a law or *plan* when, by law, its benefits are in excess of those of any private or other non-governmental plan; or
- *no-fault motor vehicle coverage* or a Motor Vehicle Financial Responsibility Act, which, according to its rules, determines its benefits after the benefits of *this plan* have been determined, or any optional *no-fault motor vehicle coverage*.

The term *plan* will be construed separately for each policy, contract, or other arrangement for benefits or services. It will also be construed separately for:

- that part of any policy, contract, or other arrangement which has the right to consider the benefits or services of other *plans* in determining its benefits; and
- that part which does not.

Primary plan means a *plan* whose benefits for health care coverage must be determined without considering the existence of any other *plan*. A *plan* is primary if:

- the *plan* has no order of benefit determination rules, or it has rules which differ from *this provision*; or
- under the order of benefit determination rules, *this plan* determines its benefits first.

School accident coverage means coverage for elementary, high school, or college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

Secondary plan is not a *primary plan*, and may consider the benefits of the *primary plan* and the benefits of any other *plan* which, under the rules of *this provision*, has its benefits determined before those of that *secondary plan*.

This plan means the benefits provided by the *policy*.

This provision means the provision for coordination between the benefits of *this plan* and other *plans*.

Other definitions which may apply to this Coordination of Benefits section appear in the Definitions sections of this *policy*.

Order of Benefit Determination

The rules to establish the order of benefit determination for each *plan* are as follows:

- A *plan* which covers the claimant as an employee, member or subscriber (that is, other than as a dependent) will determine its benefits before a *plan* which covers the claimant as a dependent. However, if the claimant is also a *Medicare* beneficiary, and as the result of the rule established by Title XVIII of the Social Security Act and implementing regulations,
 - the *plan* covering the claimant as a dependent will determine its benefits before *Medicare*; and
 - *Medicare* will determine its benefits before the *plan* covering the claimant as other than a dependent (e.g. a retired employee). Then the *plan* covering the claimant as a dependent will determine its benefits before the *plan* covering the claimant as other than a dependent.

COORDINATION OF BENEFITS (continued)

- In the event that the claimant is a dependent child whose parents are not divorced or separated, benefits for the child are determined in this order:
 - first, the *plan* which covers the claimant as a dependent child of the parent whose birthdate occurs earlier in a calendar year; and
 - second, the *plan* which covers the claimant as a dependent child of the parent whose birthdate occurs later in the calendar year.

If both parents have the same birthdate, benefits for the child are determined in this order:

- first the *plan* which covered the parent longer; and
- second, the *plan* which covered the other parent for a shorter period of time.

If the other *plan* does not contain this exact rule regarding dependents, then this rule will not apply, and the rules set forth in the other *plan* will determine the order of benefits.

- In the event that the claimant is a dependent child whose parents are divorced or separated, benefits for the child are determined in this order:
 - When the parent with custody of the child has not remarried,
 - first, the *plan* which covers the child as a dependent of the parent with custody; and
 - second, the *plan* which covers the child as a dependent of the parent without custody; or
 - When the parent with custody of the child has remarried,
 - first, the *plan* which covers the child as a dependent of the parent with custody; and
 - second, the *plan* which covers that child as a dependent of the stepparent; and
 - finally, the *plan* which covers that child as a dependent of the parent without custody; or
 - When the parents have joint custody of the child and the court does not decree which parent is responsible for the health care expenses of the child, then benefits for the child will be determined according to the birthdate rule described above.
 - If the specific terms of a court decree that one parent is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the *plan* of that parent has actual knowledge of these terms, then
 - first, the *plan* of parent with financial responsibility; and
 - second, the *plan* of the other parent.

This does not apply to any *claim period* during which any benefits are actually paid or provided before the entity has that actual knowledge.

COORDINATION OF BENEFITS (continued)

- If the specific terms of a court decree state that both parents are responsible for the health care expenses of the child but gives physical custody of the child to a particular parent, then benefits for the child will be determined according to the birthday rule described above.
- A *plan* which covers the claimant as a laid-off or retired employee, or as a dependent of that person, will determine its benefits after a *plan* covering such claimant as an employee, other than a laid-off or retired employee, or as a dependent of that person.

If a *plan* does not have a provision regarding laid-off or retired employees, which results in each *plan* determining its benefits after the other, then this rule will not apply.

- When the claimant whose coverage is provided under a federal or state continuation law is also covered under another *plan*, benefits are determined in this order:
 - first, the *plan* which covers the claimant as an employee; and
 - second, the *plan* which covers the claimant under a continuation law.

If the other *plan* does not have a provision regarding coverage provided under continuation laws, then this rule will not apply.

- When none of the rules described above establish an Order of Benefit Determination, a *plan* which has covered the claimant longer will determine its benefits before a *plan* which has covered that claimant for a shorter period of time.

Effect on Benefits

A *primary plan's* benefits are not reduced because of the existence of another *plan*.

When there are more than two *plans*, *this plan* may be a *primary plan* to one or more other *plans*, and may be a *secondary plan* to a different *plan(s)*.

When *this plan* is a *secondary plan*, benefits payable under *this plan* will be reduced so that when they are added to the benefits payable under all other *plans*, they will not exceed the total *allowable expenses* incurred by you or the *covered dependent* during the *claim period*. Benefits payable under any other *plan* include the benefits that would have been payable had the claim for them been made. Except for Part A and Part B of *Medicare*, you or the *covered dependent* must actually be covered by the other *plans*.

We will exclude the benefits payable under any *plan* in determining the above reduction if:

- that other *plan* contains a provision which requires it to determine its benefits after the benefits of *this plan*, and
- the rules set forth in the Order of Benefit Determination require us to decide the benefits of *this plan* before the other *plan*.

When a reduction is made, each benefit that would have been payable in the absence of *this provision* will be reduced proportionately or in some other manner which we consider fair. The reduced amount will be charged against any benefit limit of *this plan* that may apply.

Right to Receive and Release Necessary Information

A claimant will furnish any information necessary to implement *this provision*. We may release or obtain any information, with respect to the claimant, which we deem necessary. This information may be released to or received from any insurer, other organization, or person. This may be done without the consent of or notice to the claimant. In so acting, we will be free from any liability.

COORDINATION OF BENEFITS (continued)

Facility of Payment

When payments which should have been made under *this plan*, by the terms of *this provision*, have been made under any other *plans*, we have the right to pay to any organization making the other payments any amounts we determine are due to satisfy the intent of *this provision*. Any amount we pay in good faith will release us from further liability for that amount.

Recovery of Our Payment

If we pay more than the maximum amount required to satisfy the intent of *this provision* at that time, we have the right to recover the excess paid. We may make recovery from any persons to, or for, or with respect to whom the payments were made, or from any other insurers or organizations. This includes the reasonable cash value of any benefits provided as a service.

CLAIM PROVISIONS

Payment of Benefits

We will pay benefits when we receive all the required proof of covered loss.

To Whom Payable

We will pay dental benefits directly to the providers of dental services for *treatment* of you or your *covered dependents*, if you have assigned your benefits to the providers. We will pay dental benefits to you, if you have not assigned your benefits to the providers. After your death, we have the option to pay any benefits due to your spouse, to the providers of the *treatment*, or to your estate.

Authority

We have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the Policy. All determinations and interpretations made by us are conclusive and binding on all parties.

Filing a Claim

1. Your *dentist* should send us notice of claim for dental *treatment*. You must send us notice of all other claims. We must have written notice of any insured loss within 30 days after it occurs, or as soon as reasonably possible. You can send the notice to our *home office*, one of our regional claims offices, or to one of our agents. We need enough information to identify you as a *covered person*. If charges for dental *treatment* are expected to be \$300 or more, you can receive an estimate of benefits payable before *treatment* begins by following the procedures outlined in the Pre-estimate provision. The *preferred provider* will send notice of all dental expenses incurred under the *preferred provider plan*.
2. Within 15 days after the date of the notice, we will send you certain claim forms. The forms must be completed and sent to our *home office* or one of our regional claims offices. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss. The *preferred provider* will provide initial written proof of any dental expenses incurred under the *preferred provider plan*.
3. The time limit for filing a claim is 90 days after the date of the loss.
4. To decide our liability, we may require:
 - itemized bills,
 - proof of benefits from other sources, and
 - proof that you have applied for all benefits from other sources, and that you have furnished any proof required to get them.

For dental expenses, we may require additional information to determine our liability, including, but not limited to:

- a complete dental charting indicating extractions, missing teeth, fillings, prosthesis, periodontal pocket depths, orthodontic relationship and the dates work was previously performed, and
- preoperative x-rays, study models, laboratory and/or hospital reports.

CLAIM PROVISIONS (continued)

We will ask you to authorize the sources of medical and dental services to release your medical information. If you do not furnish any required information or authorize its release, we will not pay benefits.

If it is not reasonably possible to give proof on time, we will not deny or reduce your claim if you give us proof as soon as reasonably possible.

Physical Exam

We may ask you to be examined as often as we require at any time we choose. We will pay for any exam we require.

Limit on Legal Action

No action at law or in equity may be brought against the *policy* until at least 60 days after you file proof of loss. No action can be brought after the statute of limitations in your state has expired, but, in any case, not after 6 years from the date of loss.

Incontestability

The validity of the *policy* cannot be contested after it has been in force for 2 years, except if premiums are not paid.

Any statement made by the *policyholder* or a *covered person* will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the *covered person* or the *beneficiary*.

No statement, except fraudulent misstatement, made by a *covered person* about insurability will be used to deny a claim for a loss incurred or *disability* starting after coverage has been in effect for 2 years.

No claim for loss starting 2 or more years after the *covered person's* effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

Overpayment

If a benefit is paid under the *policy* and it is later shown that a lesser amount should have been paid, we will be entitled to a refund of the excess amount from the provider or you.

Subrogation Rights

In the event of any payments for benefits provided to you or a *covered dependent* under the *policy*, we, to the extent of our payments, will be subrogated to all rights of recovery you or your dependent have against any person or organization. You or your dependent will execute and deliver any instruments and papers as may be required and do whatever else is necessary to secure those rights to us and will do nothing after loss to prejudice our rights. If we are precluded from exercising our Subrogation Rights, we may exercise our Right to Reimbursement. This provision will only apply if you or your dependent are made whole.

Right to Reimbursement

If you or a *covered dependent*: (a) seek legal recourse (whether by suit, settlement, judgment or otherwise) against any person or organization; and (b) recover payment, in whole or in part, from any such person or organization for the benefits previously paid under the *policy*, then you or your dependent must reimburse us for all payments made under the *policy* for which you have received reimbursement.

Any payments made prior to determination of work-related injury, will be reimbursed upon determination of such payment.

CLAIM PROVISIONS (continued)

However, the reimbursement will not exceed: (a) the amount of the benefit payments made under the *policy* for which payment is recovered from any person or organization; or (b) the amount recovered from any such person or organization as payment for the same covered dental expenses.

You or your *covered dependents* are not obligated by this provision to seek legal action against any person or organization for which benefits have been paid under the *policy*.

This provision will only apply if you or your dependent are made whole.

GENERAL PROVISIONS

Entire Contract

The *policy* and the *policyholder's* application attached to it are the entire contract. Any statement made by you or the *policyholder* is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary, but not beyond 3 years before the date the error was found. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about a person is misstated, the facts will determine whether insurance is in effect and in what amount. We will equitably adjust the premium.

Individual Certificates

We will send certificates to the *policyholder* to give to each *covered person*. The certificate will state the insurance to which the person is entitled. It does not change the provisions of the *policy*.

Workers' Compensation

The *policy* is not in place of, and does not affect any state's requirements for coverage by Workers' Compensation insurance.

Agency

Neither the *policyholder*, any employer, any *associated company*, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

GENERAL PROVISIONS (continued)

Changing the Policy

The *policyholder* owns the *policy*. The *policy* may be changed at any time by an endorsement or amendment agreed upon by the *policyholder* and us. A change must be approved by one of our executive officers. No agent can change the *policy* or waive any of its provisions.

Required Data

The *policyholder* must give us all data needed to administer the insurance and determine premiums. The *policyholder* must also give us any other information we require. We may inspect the *policyholder's* records relating to the insurance provided by the *policy*.

Policyholder's Assignment

The *policyholder* may assign the *policy*. This will not affect the rights of any *covered person* or *beneficiary*. We will not be responsible for the validity of any assignment. We must receive written notice of an assignment at our *home office*.

When the Policy Ends

The *policy* will end on the earliest of the following dates:

- the date the grace period ends, if the premium has not been paid; or
- the date we cancel the *policy*, after giving the *policyholder* 60 days written notice; or
- the date we receive written notice from the *policyholder*, or the date shown in the notice, whichever is later.

The *policy* will also end if the number or percentage of persons covered under the *policy* does not meet the Minimum Participation Requirements shown in the Schedule.

If the Participation Requirements are not met, we will notify the *policyholder* 60 days in advance that insurance will end. We consider that notice is given when delivered or mailed to the last known address of the *policyholder*.

If the date the *policy* ends is not the same as the date to which premiums have been paid, the difference in premium:

- must be paid to us, if underpaid; or
- will be refunded by us, if overpaid.

PREMIUMS

Premium Payments

The *policyholder* must pay all premiums in advance at our *home office* or to one of our agents. The *policyholder* may request on any policy anniversary that the frequency of premium payment be changed to any frequency we offer for such *policy*.

Grace Period

If any premium is not paid when due, the *policy* will be in default on that date. The *policyholder* has a grace period of 31 days after that date to pay the premium. In any case, the *policyholder* must pay the premium for coverage in force during the grace period.

Calculation of Premiums

The first premium is due on the effective date. Future premiums are due on each premium due date. The premium is based on the premium rate and the amount of insurance. We will furnish premium rates to the *policyholder* with an explanation of how to apply them.

Our Right to Change Premium Rates

We may change the premium rate:

- after the first policy anniversary; or
- when our liability changes.

Unless our liability changes:

- we will not change the rates more than once in any period of 12 consecutive months; and
- we will give the *policyholder*:
 - 60 days advance written notice of an increase in rates of 25% or more, which is not due to a change requested by the *policyholder*; and
 - 31 days advance written notice of an increase in rates for any other reason.

ENDORSEMENTS AND AMENDMENTS

APPLICATION

to Union Security Insurance Company

by Wisconsin Evangelical Lutheran Synod

for group policy no. G 5,298,449

This application is executed in duplicate. One copy is to be attached to the *policy*. The other is to be returned to Union Security Insurance Company.

It is agreed that this Application replaces any prior application for the *policy*.

10 or more lives must be insured on the Effective Date of the *policy*. In addition, the number of lives to be insured on that date must be 20% of those eligible for insurance at that time.

Wisconsin Evangelical Lutheran Synod

(Full or Corporate Name of Applicant)

by _____

(Signature and Title)

Signed at _____

Date _____

Witness _____

(To be signed by Resident Agent where required by law)

This copy is to remain attached to the *policy*.

Union Security Insurance Company 2323 Grand Boulevard Kansas City Missouri 64108-2670

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Wisconsin Evangelical Lutheran Synod

(Full or Corporate Name of Applicant)

by _____
(Signature and Title)

Signed at _____ Date _____

Witness _____
(To be signed by Resident Agent where required by law)

This copy is to be returned to the *home office*.

This copy to be returned to the Risk Operations address listed below:
Union Security Insurance Company—Risk Operations/Case Issue
P.O. Box 830069, Birmingham, AL 35282-8320

Union Security Insurance Company 2323 Grand Boulevard Kansas City Missouri 64108-2670