American Family Life Assurance Company of Columbus

CERTIFICATE OF INSURANCE FOR GROUP DENTAL INSURANCE

Underwritten by: American Family Life Assurance Company of Columbus
Worldwide Headquarters
1932 Wynnton Road
Columbus, Georgia 31999

Administrator: Aflac Benefits Solutions, Inc.
4211 W Boy Scout Blvd
Tampa, FL 33607

Claims Administrator: SKYGEN USA, LLC
W140, N8981 Lilly Rd
Menomonee Falls, WI 53051

About Your Insurance – This Certificate explains the dental insurance coverage under the Policy issued to the Policyholder, which is underwritten by American Family Life Assurance Company of Columbus (a stock company hereinafter called: We, Our, Us, or Aflac). The Policy provides benefits for the Insured Persons (hereinafter called: You or Your). Read it closely to become familiar with Your plan.

Coverage is effective as of the Certificate Effective Date shown on Your ID card.

Terms important to understanding this Certificate are defined in the Definitions section or in separate Certificate provisions sections and are capitalized in this Certificate.

Important Notice – Benefits are payable only for listed Covered Procedures that were both started and completed while the Insured Person is insured under the Policy, and after any applicable Waiting Periods have been served.

The Policy under which this Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice by Us to any Insured Person who claims rights or benefits under the Policy. The Policyholder is responsible for providing notice, if any, to the Insured Persons.

The Policy provides the benefits described in this Certificate for Insured Persons. This Certificate with any attached Riders, Endorsements, or Amendments, as well as the Application and Enrollment Form, make up the Certificate of Insurance. It replaces any prior Certificates of Insurance issued under the Policy.

In witness whereof, Aflac's president and secretary signed this Certificate in Columbus, Georgia, as of the Insured Member's effective date of coverage.

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

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DEFINITIONS

Actively at Work: the performance of the normal duties of Your usual job on a Full-Time basis at Your usual place of work or at another place to which You are required to travel. You will be considered to be Actively at Work while on a paid vacation day or regular non-working day.

Administrator: the entity which will provide services and/or facilities for the writing and servicing of the Policy as agreed in a separate contract with Us.

Associated Company: any company listed on the list of Associated Companies in the Schedule of Benefits. These companies must be a subsidiary of or affiliated with the Policyholder.

Calendar Year Plan: the period beginning on the Policy Effective Date and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Covered Dental Injury: an injury to a Sound Natural Tooth, sustained while the Insured Person is insured under the Policy, and which is caused solely by a sudden violent act or accident which could not be predicted in advance or avoided.

Covered Procedure: means the procedures listed in the Schedule of Covered Procedures. The procedure must be: (1) for necessary dental treatments to an Insured Person while His coverage under the Policy is in force and (2) for treatment, which has a reasonably favorable prognosis for the patient. The procedure must be performed by a:

- licensed Dentist who is acting within the scope of His license; or
- licensed Dental Hygienist acting under the supervision and direction of a Dentist, if required.

Dental Hygienist: someone who is licensed to practice dental hygiene and is acting under supervision and direction of a Dentist, if required, and within the scope of His license.

Dentist: a practitioner who is trained to practice Dentistry, has a dental license, and is operating within the scope of His license.

Effective Date: the date on which insurance coverage begins under the Policy.

Eligibility Period: the period of time that an Eligible Member must wait before He is eligible for coverage. This period, if any, is specified in the Policyholder's Application and shown on the Schedule of Benefits.

Eligible Class: a group of people who are eligible for coverage under the Policy. See the Schedule of Benefits for a list of Eligible Classes. Each person of the Eligible Class will qualify to enroll for insurance on the date He completes the required Eligibility Period.

Eligible Dependent: someone who is residing in the United States and who is:

- Your legally married spouse or lawful domestic partner; or
- Your or Your spouse's natural child, stepchild, legally adopted child, child in Your custodial care pursuant to a court order, or child for whom You have been appointed as legal guardian, who is under age 26.

Coverage will continue for any Eligible Dependent child, regardless of age, who is incapable of self-sustaining employment by reason of intellectual or physical disability, and who became so disabled prior to age 26 and while covered under this Certificate. You must furnish proof of such disability and dependency to Us within 31 days of the Eligible Dependent child's 26th birthday. You must furnish proof of continuing disability and dependency at Our request, but not more often than annually, after the two-year period following the Eligible Dependent child's 26th birthday.

Eligible Member: a person who belongs to an Eligible Class.

Emergency Treatment: any Service, which is rendered as the direct result of an unforeseen occurrence or combination of circumstances, which requires immediate, urgent action or remedy.

Full-Time: a regular workweek as shown in the description of Eligible Classes in the Schedule of Benefits. We have the right to verify the hours worked by reviewing payroll records and/or income tax records.

Functioning Natural Tooth: a Natural Tooth which is performing its normal role in the mastication (i.e., chewing) process in the Insured Person's upper or lower arch and which is opposed in the Person's other arch by another Natural Tooth or prosthetic (i.e., artificial) replacement. Third Molars are not considered Functioning Natural Teeth for purposes of the Policy.

Group: the employer, union, trust, association, or other eligible entity or organization to which the Policy is issued.

He, Him, His: refers to the male or female gender.

In-Network Benefits: dental benefits provided under this Certificate for Covered Procedures that are provided by a Participating Provider. We recommend that You verify the provider's participation status in the network.

In-Network Only Plan: a plan that provides benefits for Services performed by Participating Providers only. Benefits are not provided under an In-Network Only Plan for Services performed by Non-Participating Providers, except for Emergency Treatment with a Covered Procedure or a Covered Procedure performed in a Limited Access Area.

Initial Term: the period following the Group's initial Effective Date and shown in the Schedule of Benefits. Rates are guaranteed not to change during this period.

Insured Dependent: an Eligible Dependent of an Insured Member for whom insurance under the Policy has become effective.

Insured Member: a person who is an Eligible Member of an Eligible Class, who has qualified for insurance by completing the Eligibility Period, and for whom insurance under the Policy has become effective.

Insured Person: an Insured Member and Insured Dependents.

Late Entrant: any Eligible Member or Eligible Dependent enrolling outside the Policyholder's initial Eligibility Period as indicated in the Schedule of Benefits. Benefits may be limited for Late Entrants under the Takeover of Existing Coverage section of this Certificate, if applicable.

Limited Access Area: an area where there are no Participating Providers within a driving distance of 50 miles from Your primary residence.

Maximum Reimbursement: the amount used to determine the maximum amount of charges of Covered Procedures to reimburse Participating Providers and, if applicable, Non-Participating Providers. There are three types of Maximum Reimbursements based on the plan that is issued:

- **Allowable Charge (AC):** When a Participating Provider performs a Covered Procedure, the Allowable Charge is the lesser of: (a) the actual dental charge; or (b) the amount that the Dentist has agreed with Us to accept as payment in full for a dental Service. Unless the Policyholder has selected an In-Network Only Plan, when a Non-Participating Provider performs a Covered Procedure, the Allowable Charge is the lesser of: (a) the actual dental charge; or (b) the "customary charge" for the dental Service. We determine the "customary charge" from within the range of charges made for the same Service by other providers of similar training or experience in that general geographic area.
- **Maximum Allowable Charge (MAC)**: When a Participating Provider performs a Covered Procedure, the MAC is the lesser of: (a) the actual dental charge; or (b) the amount that the Dentist has agreed with Us to accept as payment in full for a dental Service. Unless the Policyholder has selected an In-Network Only Plan, when a Non-Participating Provider performs a Covered Procedure, the MAC is the lesser of: (a) the actual dental charge; or (b) a percentile of the "customary charge" for the dental Service. We determine the percentile of the "customary charge" from within the range of charges made for the same Service by other providers of similar training or experience in that general geographic area.
- **Scheduled Allowable Fee (SAF)**: Some plans may use a fee schedule to determine the amount payable for a Covered Procedure. This is the maximum charge that We allow for each Covered Procedure, regardless of the fee charged by the Dentist.

The type of Maximum Reimbursement for a Covered Procedure is shown in the Schedule of Covered Procedures.

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

Non-Participating Provider: a Dentist who is not a Participating Provider. These Dentists have not entered into an agreement with Us to limit their charges.

Out-of-Network Benefits: dental benefits provided under this Certificate for Covered Procedures that are not provided by a Participating Provider. An In-Network Only Plan does not provide these benefits, except for Emergency Treatment with a Covered Procedure or a Covered Procedure performed in a Limited Access Area.

Participating Provider: a Dentist who has been selected by the Administrator for inclusion in the Participating Provider Program. These Participating Providers agree to accept the Participating Provider Maximum Allowed Charges as payment in full for Services rendered. When dental care is given by Participating Providers, the Insured Person will generally incur less out-of-pocket cost for Services rendered.

Participating Provider Program: the Administrator's program to offer an Insured Person the opportunity to receive dental care from Dentists who are designated by the Administrator as Participating Providers.

Participating Provider Program Directory: a list that is periodically updated and consists of selected Dentists who:

- are located in Your area;
- have been selected by the Administrator to be Participating Providers; and
- have agreed to be part of the Participating Provider Program.

Plan Year: the 12-month period of time shown on the Schedule of Benefits as a Calendar Year Plan or Policy Year Plan. The type of Plan Year issued is shown in the Schedule of Benefits.

Policy: the entire contract. It consists of:

- the Policy;
- the Policyholder's Application;
- any Riders, Endorsements and Amendments;
- the Certificate of Insurance; and
- the Enrollment Form, if any.

Policy Anniversary: the month and day as shown on the Policy as the Policy Anniversary.

Policy Year Plan: for the first year, the period of time that begins on the Policy Effective Date and ends on the day before the next following Policy Anniversary. For subsequent years, it is the period of time that begins on the first and each subsequent Policy Anniversary and ends on the day before the next Policy Anniversary.

Policyholder: the Group listed in the Schedule of Benefits to which the Group Master Policy has been issued.

Premium: the amount of money paid on a recurring basis to purchase the insurance benefits provided by the Policy.

Service: means a procedure performed or supply provided by a Dentist or Dental Hygienist in connection with the dental care of an Insured Person. It is required and appropriate for treatment of the Insured Person's dental condition according to broadly accepted standards of dental care as determined by the Administrator or the Administrator's dental consultants.

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

Treatment Plan: the Dentist's report of recommended treatment on a form satisfactory to the Administrator which:

- itemizes the dental Services;
- lists the charges for each itemized Service; and
- is accompanied by supporting pre-operative X-rays and any other appropriate diagnostic materials required by the Administrator.

We, Us, Our, Aflac: American Family Life Assurance Company of Columbus.

You, Your: an Insured Member.

ELIGIBILITY PROVISIONS

To be eligible for coverage under the Policy, an individual must:

- be a person of an Eligible Class of the Policyholder, as defined in the Schedule of Benefits; and
- satisfy the Eligibility Period, if any.

The Eligible Member's Eligible Dependents are also eligible for coverage, provided that the Eligible Member becomes insured under the Policy and Dependent coverage is provided under the Policy.

Dual Eligibility Status: If both an Eligible Member and His spouse or lawful domestic partner are in an Eligible Class of the Policyholder, each may enroll individually or as a Dependent of the other, but not as both. Any Eligible Dependent child may also only be enrolled by one parent. If the spouse or lawful domestic partner carrying Dependent coverage ceases to be eligible, Dependent coverage will become effective under the other spouse's or lawful domestic partner's coverage upon Our receipt of a request for such change.

PROVISIONS

The term "Enrollment" means written or electronic enrollment in the coverage by an Eligible Member on an Enrollment Form furnished or approved by Us. Coverage will not become effective until the Eligible Members have enrolled themselves and, if applicable, their Eligible Dependents, and paid the required Premium, if any.

Initial Enrollment: Eligible Members who enroll themselves and, if applicable, their Eligible Dependents within 31 days of the Eligibility Period. Individuals who enroll after this time are considered Late Entrants.

Open Enrollment: Members may enroll themselves and their Eligible Dependents during an Open Enrollment period.

Late Entrants: Members who do not enroll themselves or their Eligible Dependents within the Initial Enrollment period, may not enroll until the next Open Enrollment period unless there is a Permitted Change in Election Event, as described below.

Permitted Change in Election Event: Members may enroll in or change their coverage outside of a designated Enrollment period if a permitted change in election event occurs, provided the Insured Member makes written application to enroll within 31 days of the event. A permitted change in election event means any of the following:

- marriage or lawful domestic partnership,
- divorce or legal separation,
- birth or adoption of a child,
- placement of a child in Your custodial care pursuant to a court order,
- You being appointed legal guardian of a child,
- death of a spouse or lawful domestic partner or child, or
- other changes as permitted by Us and the Policyholder.

EFFECTIVE DATE PROVISIONS

Eligible Members and Eligible Dependents
Coverage takes effect on the Certificate Effective Date shown on Your ID card.

Additional Dependents
The Effective Date of any newly acquired Eligible Dependent will be governed by the same rules as described above under the heading "Eligible Members and Eligible Dependents." You must complete, sign and submit to Us a new Enrollment Form for all Your Additional Dependents, including newborn and adoptive children, and submit the additional Premium, if any. However, newborn and adoptive children will be covered immediately from birth or date of placement for purposes of adoption for the first 90 days. To continue coverage beyond that 90-day period, You must notify Us in writing of the child's date of birth or date of placement for an adoptive child at any time during the 90-day period.

TERMINATION PROVISIONS

Insured Members
All of Your insurance under the Policy will terminate at 11:59 p.m. at the main office of the Policyholder on the earliest of the following dates:

- the date the Policy terminates;
- the last day of the month in which You cease to be an Eligible Member;
- the date You die; or
- on any Premium Due Date, when full payment for insurance is not made within the Grace Period.

If an event that is described above occurs, written notice must be provided to Us, by You or the Policyholder, within 31 days of such event.

Insured Dependents
Your Dependent's insurance under the Policy will terminate at 11:59 p.m. at the main office of the Policyholder on the earliest of the following dates:

- the date the Policy terminates;
- the last day of the month in which You cease to be an Eligible Member;
- the date the Insured Dependent ceases to be an Eligible Dependent;
- the date You die;
- the date the Insured Dependent dies;
- on any Premium Due Date, when full payment for insurance is not made within the Grace Period; or
- the date We receive Your request to terminate Dependent coverage subject to any limitation imposed by the Policyholder.

If an event that is described above occurs, written notice must be provided to Us, by You or the Policyholder, within 31 days of such event.

Notice Required When Your Coverage Terminates
We must be informed promptly, by You or the Policyholder, when Your status as an Eligible Member terminates for any reason. Failure to provide timely notice will not continue Your insurance past the time it would have otherwise ended as provided above.

In the event Premiums have been paid to Us on Your behalf after Your coverage should have terminated, We will refund the Premium for the period for which Premiums were paid in error up to a maximum of three Policy months or to the last Policy Anniversary, whichever is less. If We are not notified that Your coverage is terminated and We pay any benefits for Your Covered Procedures incurred after the date Your coverage terminated, the full amount of those benefits will be considered an overpayment which must be repaid to Us.

PREMIUM PROVISIONS

Payment of Premiums
Insured Persons may be required to contribute, either in whole or in part, to the cost of their insurance. This is subject to the terms established by the Policyholder. If required, You contribute to the cost of the insurance through the Policyholder, who then submits payment to Us.

Grace Period
A Grace Period of 31 days following the Premium Due Date is granted for the payment of each Premium Due Date after the first. The coverage stays in force if the Premium is paid during this Grace Period, unless We are given written notice that the insurance is to be ended before the Grace Period.

Right to Change Premiums
We have the right to change the Premium rates on any Premium Due Date after the Initial Term. After the Policy Anniversary Date, We will not increase the Premium rates more than once in a 12-month period. We will give the Policyholder written notice at least 60 days in advance of any change. All changes in rates are subject to terms outlined in the Policy.

CLAIM PROVISIONS

Notice of Claim
Written Notice of Claim must be provided to the Administrator within 60 days from the date of loss. We will not deny or reduce any claim filed after 60 days from the date of loss if it was not reasonably possible to file the claim within that 60-day period, and the claim is filed as soon as it is reasonably possible.

Claims should be sent to Our Administrator at:

American Family Life Assurance Company of Columbus
AFLAC CLAIMS
PO BOX 2015
MILWAUKEE, WI 53201

Proof of Loss
Written Proof of Loss (claim forms, medical bills, medical authorizations, or other reasonable evidence of the claim that is ordinarily required) must be furnished to Us within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

Claim Forms
You may use standard American Dental Association (ADA) approved claim forms supplied by Your Dentist or You may request forms from Us. The Claim Form must identify the treatment performed in terms of the ADA Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request x-rays, narratives and other diagnostic information, as We see fit, to determine benefits.

When We receive Notice of Claim that does not contain all necessary information or is not on an appropriate Claim Form, forms for filing Proof of Loss will be sent to the claimant along with a request for the missing information. If these forms are not sent within 15 days, the claimant will meet the Proof of Loss requirements if We are given written proof of the nature and extent of the loss. Proof of Loss must be given within one year after it is due, unless You are legally incapable of doing so.

Payment of Claims
All benefits will be payable to You, unless assigned by You or by operation of law. Any accrued benefits unpaid at Your death will be paid to Your estate. Any payment made by Us in good faith pursuant to this provision will fully release Us to the extent of such payment.

Time of Payment of Claims
All benefits under the Policy will be paid immediately as they become payable. However, no benefits will be paid until the required Proof of Loss has been submitted to Us.

Recovery of Overpayments
We reserve the right to deduct from any benefits properly payable under the Policy the amount of any payment that has been made:

- in error; or
- pursuant to a misstatement contained in a Proof of Loss; or
- pursuant to fraud or misrepresentation made to obtain coverage under the Policy within two years after the date such coverage commences; or
- with respect to an ineligible person; or
- pursuant to a claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Policy made by an Insured Person if claim payments previously were made with respect to an Insured Person.

COORDINATION OF BENEFITS (COB)

This provision applies when an Insured Person has dental coverage under more than one Plan, as defined below. The benefits payable between the Plans will be coordinated.

Definitions Related to COB

- **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.
- **Coordination of Benefits (COB):** Taking other Plans into account when We pay benefits.
- **Plan:** Any plan, including this one, that provides benefits or Services for dental expenses on a group basis. “Plan” includes group and blanket insurance and self-insured and prepaid 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.

- **Primary Plan:** The Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Plans.
- **Year:** The Calendar Year, or any part of it, during which a person claiming benefits is covered under this Plan.

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

If an Insured Person's benefits paid under this Plan are reduced due to COB, each benefit will be reduced proportionately. Only the amount of any benefit actually paid will be charged against any applicable Plan Year Benefit Maximum.

The Order of Benefit Determination

- When this is the Primary Plan, We will pay benefits as if there were no other Plans.
- When a person is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.
- When a person is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:
  - **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.
  - **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.
  - **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:
    - The Plan of the parent who has responsibility for providing insurance as determined by a court order;
    - The Plan of the parent with custody of the child;
    - The Plan of the spouse of the parent with custody; and
    - 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.
  - **Active/Inactive Employee.** The Plan which covers the person as an employee who is neither laid off nor retired (or as that employee's Dependent) is Primary over the Plan which covers that person as a laid off or retired employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.
  - **Longer/Shorter Length of Coverage**. 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.

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

Right to Make Payments to Another Plan
COB 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.

Right to Recovery
COB 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.

PART III - DENTAL INSURANCE COVERAGE PROVISIONS

DEDUCTIBLE

The Deductible is the amount of the Maximum Reimbursement which must be paid in full by You each Plan Year (or lifetime, when applicable) for each Insured Person (or to the maximum per family limit, when applicable) who incurs a Covered Procedure before any benefits are payable. The Deductible is applied chronologically according to the dates on which the Covered Procedures on a claim were completed. The amount of the Deductible is shown in the Deductible section of the Schedule of Benefits.

PERCENTAGE OF MAXIMUM REIMBURSEMENT

The Percentage of Maximum Reimbursement is the percentage of the Maximum Reimbursement that We will pay for a Covered Procedure. The percentage applicable to an Insured Person may vary by Covered Procedure and the length of time the Insured Person has been continuously covered for dental insurance. The Percentage of Maximum Reimbursement for a Covered Procedure is shown in the Schedule of Benefits.

PLAN YEAR BENEFIT MAXIMUM

The Plan Year Benefit Maximum is the maximum benefit payable by the Policy for all Covered Procedures completed in a Plan Year for an Insured Person. This maximum will apply even if an Insured Person's coverage is interrupted or if an Insured Person has been covered both as an Insured Member and as an Insured Dependent during a Plan Year. The Plan Year Benefit Maximum is listed in the Schedule of Benefits.

[Maximum Carryover Benefit
An Insured Person may be eligible to carryover a portion of His unused Plan Year Benefit Maximum as follows:

If an Insured Person submits Qualifying Claims for Covered Procedures during a Plan Year and, in that Plan Year, receives benefits that are in excess of any deductible or co-pay fees, and that, in total, do not exceed the Threshold Limit, the Insured Person will be credited a Carryover Amount for that Plan Year.

Carryover Amounts will be accrued and stored in the Insured Person's Carryover Account. If an Insured Person reaches His Plan Year Benefit Maximum, We will pay a benefit from the Insured Person's Carryover Account up to the amount stored in the Insured Person's Carryover Account. The accrued Carryover Amounts stored in the Carryover Account may not be greater than the Carryover Account Limit.

An Insured Person's Carryover Account will be eliminated, and the accrued Carryover Amounts lost, if the Insured Person has a break in coverage of any length of time, for any reason.

The Threshold Limit, Carryover Amounts, and Carryover Account Limits for this Certificate are:

- Threshold Limit: $500
- Carryover Amount: $250
- Carryover Account Limit: $1,000

Eligibility for a Carryover Amount will be established or reestablished at the time the first Qualifying Claim in a Plan Year is received for Covered Procedures performed during that Plan Year.

In order to properly calculate Maximum Carryover Benefits, claims should be submitted timely in accordance with the Proof of Loss provision found within the Claims Provision section of this Certificate. You have the right to request review of prior Maximum Carryover Benefit calculations. The request for review must be within 24-months from the date the Maximum Carryover Benefit was established.

Definitions:

- "Carryover Account" means the amount of an Insured Person's accrued Carryover Amounts.
- "Carryover Account Limit" means the maximum amount of cumulative Carryover Amounts that an Insured Person can store in His Carryover Account.
- "Carryover Amount" means the dollar amount, which will be added to an Insured Person's Carryover Account when He receives benefits in a Benefit Year that do not exceed the Threshold Limit.
- "Qualifying Claim" means a claim under Procedure Classes A, B and C, but not Class D or E.
- "Threshold Limit" means the maximum amount of benefits that an Insured Person can receive during a Plan Year and still be entitled to receive the Maximum Carryover Amount.]

WAITING PERIOD

The Waiting Period is the period of time starting on an Insured Person's Effective Date before benefits for certain Services become payable. If a Covered Procedure is started before the Waiting Period for that procedure ends, that procedure is not covered under the Policy. If an Insured Person's coverage under the Policy ends and the person later becomes insured again, that Insured Person's Effective Date is the most recent date He became an Insured Person unless stated otherwise in the Policy. The Waiting Periods for Covered Procedures are listed in the Schedule of Covered Procedures.

LIMITED ACCESS AREA

If You live in a Limited Access Area and You receive covered Dental Services from a Non-Participating Provider, We will pay the same plan allowances as if You utilized a Participating Provider. It is important to note that You will be responsible for the difference between the billed amount and Our payment. Limited Access Area does not apply outside of the United States.

BENEFITS PAYABLE FOR COVERED PROCEDURES

Upon receipt of Proof of Loss that an Insured Person has had a Covered Procedure performed, We will determine if benefits are payable.

Before We determine benefits, the Insured Person must satisfy any Waiting Periods and the Deductible. We then pay the Percentage of Maximum Reimbursement, less any Co-Pay Amount subject to the Plan Year Benefit Maximum. Additionally, the benefit payable is subject to the following:

- The Covered Procedure must start and be completed while the Insured Person's coverage is in force, except as provided in the "Takeover of Existing Coverage" section of this Certificate.
- Each Covered Procedure may be subject to specific Frequency Limitations, as shown on the Schedule of Covered Procedures.
- Other Limitations and Exclusions that may affect coverage are shown in the "Limitations and Exclusions" section of this Certificate.

An Insured Person may choose a Dentist of His choice and may choose the Services of a Dentist who is either a Participating Provider or a Non-Participating Provider. If the Policyholder has selected an In-Network Only Plan, no benefits are payable for Services performed by a Non-Participating Provider, except for Emergency Treatment with a Covered Procedure or a Covered Procedure performed in a Limited Access Area. See the Percentage of Maximum Reimbursement section of the Schedule of Benefits to determine whether the Policy includes benefits for a Non-Participating Provider.

DATE STARTED

For benefit determination purposes, the following will define the date on which certain Covered Procedures will be deemed started:

- for Full Dentures or Partial Dentures, on the date the first impression is taken;
- for Fixed Partial Dentures (including Maryland Bridges), Crowns, Inlays, Onlays and other laboratory prepared restorations, on the date the teeth are first drilled down to receive the restoration;
- for Root Canal Therapy, on the date the pulp chamber is first opened;
- for Periodontal Surgery, on the date the surgery is actually performed; and
- for all other treatment, on the date the Service is performed.

Note: If Orthodontic Services are covered, see the Schedule of Covered Procedures for Start Dates.

DATE COMPLETED

For benefit determination purposes, the following will define the date on which certain Covered Procedures will be deemed completed:

- for Root Canal Therapy, on the date the canals are permanently filled;

- for Fixed Partial Dentures (including Maryland Bridges), Crowns, Inlays, Onlays, and other laboratory prepared restorations, on the date the restoration is permanently cemented in place;
- for Dentures and Partial Dentures, on the date that the final completed appliance is first inserted in the mouth (However, no denture or partial denture will be considered completed until it is accepted by the patient.); and
- for all other treatment, on the date the procedure is started.

Note: If Orthodontic Services are covered, see the Schedule of Covered Procedures for Completion Dates.

WAIVER OF WAITING PERIOD FOR COVERED DENTAL INJURIES

We will waive any applicable Waiting Period for any Covered Procedure which is necessary for the repair of a Covered Dental Injury which is started within 60 days of the injury and completed within six months.

PRE-ESTIMATION OF BENEFITS

Whenever the charge for any treatment is expected to exceed $300, the Treatment Plan must be submitted to Us by the Dentist for review before treatment begins. The Treatment Plan should be accompanied by supporting pre-operative X-rays and any other appropriate diagnostic materials that We or Our dental consultants request.

We will notify the Insured Person's attending Dentist of the estimated benefits payable based upon the Treatment Plan. In determining the amount of benefits payable, consideration will be given to alternate procedures that may accomplish a professionally satisfactory result. If the Insured Person and His Dentist decide on a more expensive method of treatment than that pre-estimated by Us, the payment of benefits will be limited to the benefits payable for the least costly Treatment Plan. We will not pay the excess amount.

ALTERNATE BENEFITS

There is often more than one Service that can be used to treat a dental problem or disease. In determining the benefits payable on a claim, different materials and methods of treatment will be considered. The amount payable will be limited to the least costly Service, which meets broadly accepted standards of dental care. The Insured Person and His Dentist may decide on a more costly procedure or material than We have determined to be satisfactory for the treatment of the condition. We will pay a benefit toward the cost of the more expensive procedure or material, but payment will be limited to the benefits payable for the least costly Service. We will not pay the excess amount.

LIMITATIONS AND EXCLUSIONS

We will not pay benefits if You fail to cooperate with Our investigation into the validity of Your claim. No benefits are payable under the Policy for the Services listed below. In addition, the Services listed below will not be recognized toward the satisfaction of any Deductible:

- any Services which are not included in the Schedule of Covered Procedures;
- any Service started or appliance installed before the Effective Date or after the date coverage terminates, except as provided in the "Takeover of Existing Coverage" section of this Certificate;
- any Service, which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years;
- any procedure We determine is not necessary, does not offer a favorable prognosis, does not have uniform professional endorsement or is experimental in nature;
- crowns, inlays, onlays, cast restorations, or other laboratory prepared restorations on teeth, which may be satisfactorily restored with an amalgam or composite resin filling;
- any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations unless such procedure is listed in the Schedule of Covered Procedures;
- appliances, Services or procedures relating to: (1) the change or maintenance of vertical dimension; (2) restoration of occlusion (unless otherwise noted in the Schedule of Covered Procedures—only for occlusal guards); (3) splinting; (4) correction of attrition, abrasion, erosion or abfraction; (5) bite registration or (6) bite analysis;
- replacement of bridges unless the bridge is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
- replacement of full or partial dentures unless the prosthetic appliance is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;

- replacement of crowns, inlays or onlays unless the prior restoration is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
- for orthodontic treatment unless otherwise listed as a Covered Procedure in the Schedule of Covered Procedures;
- Services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain unless such procedure is listed as a Covered Procedure in the Schedule of Covered Procedures;
- charges for implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized Services or attachments unless such procedures are listed as Covered Procedures in the Schedule of Covered Procedures;
- athletic mouth guards; myofunctional therapy; treatment for malignancies, cysts and neoplasms; failure to keep scheduled appointment; charges for completion of claim forms; infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; charges for travel time; transportation costs; professional advice; treatment of jaw fractures; orthognathic surgery; exams required by a third party other than Us; personal supplies (e.g., Waterpik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
- prescription drugs, premedication, pharmaceuticals, or analgesia;
- dental disease, defect or injury caused by a declared or undeclared war or any act of war or terrorism or taking part in an insurrection or riot; the commission or attempted commission of afelony or to which a contributing cause was the insured's being engaged in an illegal occupation; an intentionally self-inflicted injury or attempted suicide while sane or insane;
- dental treatment not approved by the American Dental Association or which is clearly experimental in nature;
- any charge for a Service for which benefits are available under Worker’s Compensation or an Occupational Disease Act or Law, even if the Insured Person did not purchase the coverage that is available to Him;
- any charge for a Service performed outside of the United States other than for Emergency Treatment. Benefits for Emergency Treatment performed outside of the United States are limited to a maximum of $100 per year;
- Services performed by a Dentist who is a member of the Insured Person's family. Insured Person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents;
- the initial placement of a removable full denture or a removable partial denture unless it includes the replacement of a Functioning Natural Tooth extracted while the person is insured under the Policy;
- the initial placement of a fixed partial denture including a Maryland Bridge, unless it includes the replacement of a Functioning Natural Tooth extracted while the person is insured under the Policy, provided that tooth was not an abutment to an existing partial denture that is less than five years old or to an existing fixed partial denture or Maryland Bridge which is less than seven years old or other Frequency Limitation as stated in Schedule of Covered Procedures. Benefits are payable only for the replacement of those teeth which were extracted while the person was insured under the Policy;
- the replacement of teeth beyond the normal complement of 32;
- the replacement of an existing removable partial denture with a fixed partial denture unless upgrading to a fixed partial denture is essential to the correction of the Insured Person's dental condition;
- local anesthetic as a separate fee;
- any Treatment Plan which involves full-mouth reconstruction by the removal and reestablishment of occlusal contacts of 10 or more teeth with restorations, crowns, onlays, inlays, fixed partial dentures, dentures, or any combination of these Services; and
- any Services (except Emergency Treatment with a Covered Procedure or a Covered Procedure performed in a Limited Access Area) provided by a Non-Participating Provider, if the Policyholder has selected an In-Network Only Plan.

UNBUNDLING

Unbundling may occur when certain complicated dental Services are performed and other less extensive Services are performed at the same time as component parts of the primary Service. For benefit purposes under the Policy, these less extensive Services are considered to be integral components of the primary Service. Even if the Dentist bills separately for the primary Service and each of its component parts, the total benefit payable for all related charges will be limited to the benefits payable for the primary Service.

REVIEW OF CLAIM

If We send You a written statement denying Your claim in whole or in part, You may, within 60 days after Your receipt of such written statement, submit a written appeal to Us. A written decision with respect to the appeal shall be sent to You

within 30 days after its receipt, unless special circumstances exist which require additional time, in which case a written decision with respect to the appeal will be sent to You as soon as possible.

TAKEOVER OF EXISTING COVERAGE

The following provisions are applicable if this dental plan is replacing an existing group dental plan in force (referred to as "Prior Plan") at the time of application. These are called "Takeover Benefits." The Schedule of Benefits shows if Takeover Benefits apply.

Waiting Period Credit
When We immediately take over an entire dental group from another insurance company, those Insured Persons of the Prior Plan on the day immediately prior to the takeover Effective Date will receive Waiting Period credit if they are eligible for coverage on the Policy Effective Date of Our plan. The Waiting Period credit does not apply to new Insured Persons, Eligible Dependent add-ons, or Late Entrants.

Deductible Credits

- For Calendar Year Plans: Deductible credits will be granted for the amount of the Deductible satisfied under the Prior Plan during the current Calendar Year.
- For Policy Year Plans: The Deductible will begin anew on the Policy's takeover Effective Date, which marks the start of a new Policy Year.

Plan Year Benefit Maximum

- For Calendar Year Plans: All paid benefits applied to the Plan Year Benefit Maximum under the Prior Plan will also be applied to Plan Year Benefit Maximum under this Certificate during the current Calendar Year.
- For Policy Year Plans: The Plan Year Benefit Maximum will begin anew on the Policy's takeover Effective Date, which marks the start of a new Policy Year.

If You had Orthodontic Services coverage under the Prior Plan and You have Orthodontic Services coverage under this Certificate, We will not pay benefits for Orthodontic Services expenses unless:

- You submit proof that the Maximum Lifetime Benefit for Orthodontic Services for this Certificate was not exceeded under the Prior Plan;
- orthodontic treatment was started, and bands or appliances were inserted while insured under the Prior Plan; and
- orthodontic treatment is continued for the Insured Person under this Certificate.

If You submit the required proof, the Maximum Lifetime Benefit for Orthodontic Services will be the lesser of this Certificate's Maximum Lifetime Benefit for Orthodontic Services or the Prior Plan's Orthodontic Services Maximum Lifetime Benefit. The Orthodontic Services Maximum Lifetime Benefit payable under this Certificate will be reduced by the amount paid or payable under the Prior Plan.

Verification
The Policyholder's Application must be accompanied by a current month's billing from the current dental carrier, a copy of an in-force Certificate, as well as proof of the Effective Date for each Insured Person, if insured under the Prior Plan.

Prior Carrier's Responsibility
The prior carrier is responsible for costs for procedures begun prior to the Effective Date of this coverage.

Prior Extractions
If: (1) treatment is dentally necessary due to an extraction which occurred before the Effective Date of this coverage while an Insured Person was covered under the Prior Plan, and (2) treatment would have been covered under the Policyholder's Prior Plan, We will apply the expenses to this plan as long as they are Covered Procedures under both Our Policy and the Prior Plan.

Coverage for Treatment in Progress
If an Insured Person was covered under the Prior Plan on the day before this coverage replaced the Prior Plan, the Insured Person may be eligible for benefits for treatment already in progress on the Effective Date of this coverage. However, the expenses must be Covered Procedures under both this coverage and the Prior Plan. This is subject to the following:

- Extension of benefits under Prior Plan. We will not pay benefits for treatment if:
  - the Prior Plan has an Extension of Benefits provision;
  - the treatment expenses were incurred under the Prior Plan; and

- the treatment was completed during the extension of benefits.
- No extension of benefits under Prior Plan. We will pro-rate benefits according to the percentage of treatment performed while insured under the Prior Plan if:
  - the Prior Plan has no extension of benefits when that plan terminates;
  - the treatment expenses were incurred under the Prior Plan; and
  - the treatment was completed while insured under this Certificate.
- Treatment not completed during the extension of benefits. We will pro-rate benefits according to the percentage of treatment performed while insured under the Prior Plan and during the extension if:
  - the Prior Plan has an extension of benefits;
  - the treatment expenses were incurred under the Prior Plan; and
  - the treatment was not completed during the Prior Plan's extension of benefits.

We will consider only the percentage of treatment completed beyond the extension period to determine any benefits payable under this coverage.

Insert

PART IV – SCHEDULE OF COVERED PROCEDURES