

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

(a New York Stock Life and Health Insurance Company)

Home Office:

485 Madison Avenue
New York, New York 10022
212-355-4141

Dental insurance. The insurance evidenced by this certificate provides DENTAL insurance only.
Optional benefits, if elected, are attached by rider.

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

The Policy constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy. Benefit payment is governed by all the terms, conditions and limitations of the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment takes effect and nothing in the group policy will invalidate or impair any rights granted to the certificateholder in the certificate.

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

This Certificate was issued on the basis that the information on Your application was correct and complete. If any information on the application was not correct, write to Us within ten days of receipt of this Certificate.

READ YOUR CERTIFICATE CAREFULLY.



Rachel Lipari
President



Adam C. Vandervoort
Secretary

GROUP DENTAL INSURANCE CERTIFICATE

NON-PARTICIPATING

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Covered Procedures	Benefit Waiting Period (Months)	Co-Insurance Calendar Year 1 In Network
PREVENTIVE CARE		
Prophylaxis (the cleaning and scaling of teeth) – limited to 1 per 6 months	0	100%
One topical application of Fluoride for dependent children under age 19 - limited to 1 per calendar year	0	100%
Routine oral exams – limited to 12 per 6 months	0	100%
Consultation - other than treating doctor	0	100%
Comprehensive Oral Exam	0	100%
Problem Focused Exams	0	100%
Sealants – limited to dependents under age 14, one treatment per tooth (permanent bicuspids and molars) and no less than 36 months apart	0	100%
Space Maintainers - the initial appliance for dependent children under age 13, including all adjustments within the 6 month period immediately following installation	0	100%
DIAGNOSTIC CARE		
Intra-Oral Occlusal Film	0	90%
Bitewing X-rays (up to a set of 4) – limited to 1 per calendar year	0	90%
Full Mouth X-rays (Panoramic Film or Full Series) – no less than 36 months apart	0	90%
Periapicals	0	90%
BASIC CARE		
Palliative Treatment – if no other service was rendered except x-rays	4	80%
Amalgam Restorations	4	80%
Composite Restorations – limited to anterior teeth and bicuspids	4	80%
Sedative Fillings	4	80%
Pin Retention - per tooth, in addition to restoration	4	80%
Simple Extractions	4	80%
Occlusal Adjustment – limited or complete	4	80%
MAINTENANCE PROSTHODONTICS	4	80%
Denture Repairs	4	80%
Denture Adjustments	4	80%
Denture Rebase – no less than 24 months apart	4	80%
Denture Reline - no less than 24 months apart	4	80%
Two Tissue Conditionings – no less than 24 months apart	4	80%
MAJOR CARE		
ORAL SURGERY		
General Anesthesia or I.V. Sedation when administered with oral surgery	15	50%
Surgical Extractions	15	50%
Surgical Access of an unerupted tooth	15	50%
Biopsy	15	50%
Surgical Repositioning of teeth	15	50%
Transseptal Fiberotomy	15	50%
Alveoloplasty	15	50%
Vestibuloplasty	15	50%
Surgical Excision of Lesions	15	50%
Removal of Exostosis and Torus	15	50%
Incision and Drainage of Abscess	15	50%
Frenulectomy	15	50%
RESTORATIONS		
Inlays	15	50%

Onlays	15	50%
Crown – single restorations only	15	50%
Inlay Recementation	15	50%
Crown Recementation	15	50%
Core Build-Up - including any pins	15	50%
Post and Core – in addition to crown	15	50%
Veneers – excluding cosmetic; restorative only	15	50%
ENDODONTICS		
Pulp Cap – direct & indirect	15	50%
Pulpal Therapy - limited to primary teeth	15	50%
Pulpotomy – limited to primary teeth	15	50%
Pulpal Debridement	15	50%
Root Canals	15	50%
Retreatment of Previous Root Canals	15	50%
Apexification/Recalcification	15	50%
Apicoectomy	15	50%
Retrograde Filling	15	50%
Hemisection	15	50%
Root Amputation	15	50%
PERIODONTICS		
Scaling and Root Planing – no less than 24 months apart	15	50%
Full Mouth Debridement	15	50%
Periodontal Maintenance Procedure - no less than 6 months apart	15	50%
Localized Delivery of Chemotherapeutic Agents – limited to 3 sites per quad and no less than 24 months apart	15	50%
Gingivectomy	15	50%
Gingival Flap Procedure	15	50%
Apically Positioned Flap	15	50%
Clinical Crown Lengthening – hard tissue	15	50%
Osseous Surgery – no less than 24 months apart	15	50%
Bone Replacement Graft	15	50%
Biologic Materials to Aid in Tissue Regeneration	15	50%
Guided Tissue Regeneration	15	50%
Surgical Revision Procedure - per tooth	15	50%
PedicleSoft Tissue Grafts	15	50%
Free Soft Tissue Graft	15	50%
Subepithelial Connective Tissue Graft	15	50%
Distal or Proximal Wedge Procedure	15	50%
Soft Tissue Allograft	15	50%
Combined Connective Tissue and Double Pedicle	15	50%
PROSTHODONTICS CARE		50%
Complete Dentures - including adjustments made within 6 months after installation	15	50%
Partial Dentures - including adjustments made within 6 months after installation	15	50%
Fixed Partial Denture - pontics	15	50%
Fixed Partial Denture - retainers (inlays/onlays and crowns)	15	50%
ORTHODONTIC CARE		
Orthodontic treatment for dependent children under age 19. This Certificate will pay the lesser of: (1) either 25% of the maximum orthodontic benefits; or (2) the Dentist's initial fee after coinsurance. The remaining balance is paid each month in even amounts.	NC	NC

SECTION 1 - INTRODUCTION

This Certificate of Insurance is composed of 3 parts:

1. The Schedule of Benefits;
2. This Certificate; and
3. The Optional Benefit Riders as selected by the Policyholder and reflected on Your Schedule of Benefits.

This Certificate of Insurance describes Your eligibility and enrollment requirements, Your benefits, the exclusions and limitations applicable to Your benefits, and those things You need to do in order to be entitled to Your complete benefits.

Specific definitions apply to this Certificate of Insurance. Please see the Definitions section of the Certificate of Insurance for definitions of specific terms.

SECTION 2 - DEFINITIONS

The terms listed below, when used in this Certificate, will have the following meanings:

Calendar Year: The period of time beginning January 1st and ending on December 31st of the same year. The first Calendar Year of the Certificate will begin on the date Your coverage becomes effective and end on the first December 31st after a Covered Person's Effective Date of coverage.

Calendar Year Maximum Amount: The maximum amount of benefits payable under the Certificate in a Calendar Year. The Calendar Year Maximum is shown on the Schedule of Benefits page. Prosthodontics and orthodontia, if covered, have a separate Calendar Year Maximum Amount.

Certificateholder: The Insured Person under the Policy.

Child:

1. An Insured Person's natural child;
2. An Insured Person's lawfully adopted child;
3. A child placed for adoption with an Insured Person;
4. An Insured Person's stepchild;
5. An Insured Person's foster child;
6. A child for whom the Insured Person has been appointed legal guardian by a court of competent jurisdiction and who resides with and who is dependent upon the Insured Person in a regular parent-child relationship; or
7. A Child of the Insured Person for whom the Insured Person is obligated to provide medical child support pursuant to a Qualified Medical Support Order, provided that the requirement for qualifications of the order as outlined in the Policy are met.

Co-Insurance: The percentage paid by the plan after the Deductible is met up to the Calendar Year Maximum Amount. The Co-Insurance percentage is shown in the Schedule of Benefits.

Company: Standard Security Life Insurance Company of New York. Also hereinafter referred to as We, Us and Our.

Copay/Copayment: The fixed dollar amount specified in the Schedule of Benefits that is payable by a Covered Person to a provider at the time of service in connection with specific Covered Charges.

Covered Charge: The Reasonable and Customary Charge for a Medically Necessary Covered Procedure which is performed by a Dentist or a Dental Hygienist acting under the supervision and direction of a Dentist.

Covered Person: A person who has satisfied all of the following requirements:

- he or she is eligible for coverage under the Policy, either as an Insured or as a Dependent;
- he or she has been accepted for coverage under the Policy or has been automatically added;
- premium has been paid for him or her; and
- his or her coverage has become effective and has not terminated.

Covered Persons are shown on the Identification Card.

Covered Procedure: The procedures listed in the Schedule of Covered Procedures. The procedure must be: (1) for Medically Necessary dental treatment to a Covered Person while his or her coverage under the Policy is in force and (2) for treatment, which in Our opinion, has a reasonably favorable prognosis for the patient. The procedure must be performed by a:

1. licensed Dentist who is acting within the scope of his or her license;
2. licensed Physician performing dental services within the scope of his or her license; or
3. licensed Dental Hygienist acting under the supervision and direction of a Dentist.

Deductible: The dollar amount for Covered Procedures that a Covered Person must pay in a Calendar Year before benefits are payable under this Certificate. The Deductible is shown on the Schedule of Benefits. Each Covered Person must satisfy the Deductible before benefits are payable. After three Covered Person's have each satisfied the Deductible, no additional Deductible will be required for other Family Members who are Covered Persons for the remainder of the Calendar Year.

Dentist: A person who is a legally licensed doctor of dental surgery, dental medicine or dental science in the state where services are rendered and is acting within the scope of that license.

Dental Hygienist: A person who is licensed to practice dental hygiene in the state where services are rendered and is acting under the supervision and direction of a Dentist and within the scope of that license.

Dependent: An Insured Person's:

1. Lawful spouse;
2. Unmarried Child who is primarily dependent upon the Insured Person for support and maintenance and is:
 - A. Less than 19 years of age; or
 - B. Between 19 and 25 years of age; provided however, that the Child is dependent upon the Covered Person for support and maintenance and a full-time student actively attending an accredited college, vocational or high school. Full-time, as used in this definition, means actively attending at least 12 hours of class a week or, if less, attending the minimum hours of class the school considers as full-time status;

Dependent does not include anyone who:

- is in the armed forces of any country; or
- has coverage under the Policy as a Certificateholder or Dependent of another person.

- **Domestic Partners:**
 1. Registration as a domestic partnership or, in the case of retirees living outside the City, an alternative affidavit of domestic partnership;
 2. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
 3. Evidence of two or more of the following:
 - a. A joint bank account
 - b. A joint credit card or charge card
 - c. Joint obligation on a loan
 - d. Status as an authorized signatory on the partner's bank account, credit card or charge card
 - e. Joint ownership of holdings or investments
 - f. Joint ownership of residence
 - g. Joint ownership of real estate
 - h. Listing of both partners as tenants on the lease of the shared residence
 - i. Shared rental payments of residence (need not be shared 50/50)
 - j. Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence
 - k. A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50)
 - l. Shared household budget for purposes of receiving government benefits
 - m. Status of one as representative payee for the other's government benefits
 - n. Joint ownership of major items of personal property (e.g., appliances, furniture)
 - o. Joint ownership of a motor vehicle
 - p. Joint responsibility for child care (e.g., school documents, guardianship)
 - q. Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50)
 - r. Execution of wills naming each other as executor and/or beneficiary
 - s. Designation as beneficiary under the other's life insurance policy
 - t. Designation as beneficiary under the other's retirement benefits account
 - u. Mutual grant of durable power of attorney
 - v. Mutual grant of authority to make health care decisions (e.g., health care power of attorney)
 - w. Affidavit by creditor or other individual able to testify to partners' financial interdependence
 - x. Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

Emergency: A dental condition characterized by the sudden onset of acute symptoms of sufficient severity that the absence of immediate dental attention could reasonably result in:

- permanently placing the Covered Person's health in jeopardy;
- causing other serious dental or health consequences; or
- causing serious impairment of dental function.

We will make the final determination as to whether or not a condition is an Emergency.

Experimental/Investigational: A drug, device or medical or dental care or treatment will be considered experimental/investigational if:

- The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- The informed consent document utilized with the drug, device, medical or dental care or treatment states or indicates that the drug, device, medical or dental care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
- The drug, device, dental care or treatment or the patient informed consent document utilized with the drug, device or medical or dental care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;

- Reliable Evidence shows that the drug, device or medical or dental care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis; or
- Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device or medical or dental care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

Reliable Evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical or dental care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical or dental care or treatment. Covered Procedures will be considered in accordance with the drug, device or medical or dental care at the time the expense is incurred.

Family Member: A person who is related to a Covered Person in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother and stepsister), or Child.

In-Network Provider: A Dentist who is under contract with Us or Our subcontracted vendor.

Insured/Insured Person/Member: The individual named on the Schedule of Benefits as the Insured who has: (a) submitted an application for coverage on himself or herself, his or her Dependents, or both; (b) meets the eligibility and effective date provisions set forth in the Certificate evidencing coverage under the Policy; (c) is approved for coverage by Us; and (d) for whom all applicable premiums are paid, and therefore has coverage under the Policy.

Medically Necessary:

I. YOUR RIGHT TO AN EXTERNAL APPEAL

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Plan has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

II. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS NOT MEDICALLY NECESSARY

If the plan has denied coverage on the basis that the service is not medically necessary, you may appeal to an external appeal agent if you satisfy the following two (2) criteria:

- The service, procedure, or treatment must otherwise be a Covered Service under the Subscriber Contract; and
- You must have received a final adverse determination through the [first level of the] Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree to waive any internal appeal.

III. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

- The service must otherwise be a Covered Service under this Subscriber Contract; and
- You must have received a final adverse determination through the [first level of the] Plans internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal.

In addition, your attending physician must certify that you have a life-threatening or disabling condition or disease. A “life-threatening condition or disease” is one which, according to the current diagnosis of your attending physician, has a high probability of death. A “disabling condition or disease” is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a “disabling condition or disease” is any medically determinable physical or mental impairment of comparable severity.

Your attending physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard service or procedure covered by the Plan **or** one for which there exists a clinical trial (as defined by law).

In addition, your attending physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending physician should contact the State in order to obtain current information as to what documents will be considered or acceptable); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered).

For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

IV. THE EXTERNAL APPEAL PROCESS

If, through the first level of the Plan’s internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and the Plan have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. The Plan will provide an external appeal application with the final adverse determination issued through the first level of the Plan’s internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from the New York State Insurance Department at 1-800-400-8882. Submit the completed application to the Insurance Department at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which the Plan based its denial, the external appeal agent will share this information with the Plan in order for it to exercise its right to reconsider its decision. If the Plan chooses to exercise this right, the Plan will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Plan does not have a right to reconsider its decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your physician, or the Plan. If the external appeal agent requests additional information, it will have five (5) additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two (2) business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within three (3) days of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Plan by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns the Plan's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, the Plan will provide coverage subject to the other terms and conditions of this subscriber contract. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and the Plan. The external appeal agent's decision is admissible in any court proceeding.

The following language will be used by plans opting to charge a fee

The Plan will charge you a fee of (insert any amount up to \$50) for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. The Plan will also waive the fee if the Plan determines that paying the fee would pose a hardship to you. If the external appeal agent overturns the denial of coverage, the fee shall be refunded to you.

V. YOUR RESPONSIBILITIES

It is your RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Insurance Department. You may appoint a representative to assist you with your external appeal request, however, the Insurance Department may contact you and request that you confirm in writing that you have appointed such representative.

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. The Plan has no authority to grant an extension of this deadline.

COVERED SERVICES/EXCLUSIONS

In general, the Plan does not cover experimental or investigational treatments. However, the Plan shall cover an experimental or investigational treatment approved by an external appeal agent in accordance with Section ____ of this subscriber contract. If the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

Out-of-Network Provider: A Dentist, located within the PPO Service Area, who is not under contract with Us or Our subcontracted vendor.

Policy: The contract providing the benefits described herein issued to the Policyholder.

Policyholder: Means the Group, in whose name the Policy is issued, as shown on the Schedule of Benefits.

PPO Service Area: The geographical area in which We have arranged to provide PPO services to Covered Persons.

Preferred Provider Organization (PPO): A designated entity within the PPO Service Area under contract with Us or Our subcontracted vendors to provide certain services at a reduced reimbursement rate within a PPO Service Area. We or Our subcontracted vendors will contract with In-Network Providers to provide services covered by the Policy.

Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal law, and approved for general use by the Food and Drug Administration.

Reasonable and Customary Charge: The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the Geographic Area in which the charge is incurred. The most common charge means the lesser of:

- the actual amount charged by the provider;
- the negotiated rate;
- the usual charge which would have been made by a provider (Dentist, Hospital, etc) for the same or a comparable professional services, drugs, procedures, devices, supplies or treatment within the same Geographic Area, as determined by Us.

“Geographic Area” means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; or a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

We, Our, Us, The Company: Standard Security Life Insurance Company of New York.

You, Your: The person named on the Schedule of Benefits as the Insured Person.

SECTION 3 – ELIGIBILITY FOR INSURANCE AND EFFECTIVE DATE OF COVERAGE

ELIGIBILITY

Insured Person

An individual will become eligible for coverage under the Policy upon meeting all the following requirements:

1. the individual is under age sixty-four and one-half (64 ½);
2. the individual is a member of the Group to which the Policy is issued;
3. the individual has submitted a written request, upon a form approved by Us, seeking to apply for coverage under the Policy as an Insured Person;
4. the individual is insurable pursuant to Our then current underwriting guidelines; and
5. the individual must be a permanent resident of the United States.

Dependent Insurance

A Dependent of the Insured Person will become eligible for coverage under the Policy upon meeting all of the following requirements:

1. the individual is under age sixty-four and one-half (64 ½);
2. the individual otherwise meets the definition of Dependent;
3. the Insured Person has submitted a written request, upon a form approved by Us, seeking to apply for coverage on the individual, under the Policy as a Dependent;
4. the individual is insurable pursuant to Our then current underwriting guidelines; and
5. the individual must be a permanent resident of the United States.

Under this Section 3, all evidence that the individual is insurable pursuant to Our current underwriting guidelines shall be provided without expense to Us.

EFFECTIVE DATE OF COVERAGE

Insured Person Insurance

The insurance coverage under the Policy shall become effective for the Insured Person on the premium due date coincident with or next following the date on which We approve his or her written request for coverage and he or she pays the applicable premium.

Dependent Insurance

The insurance coverage under the Policy shall become effective for an eligible Dependent on the premium due date coincident with or next following the date on which We approve the Insured Person's written request for coverage and the applicable premium is paid.

Newborns

Coverage will be effective for a newborn child of the Insured Person for thirty-one (31) days following the moment of birth. Coverage shall continue beyond the thirty-one (31) day period provided that the Insured meets the following requirements:

1. makes a written request for coverage, on forms approved by Us, within thirty-one (31) days from the birth; and
2. makes the required premium payment, if applicable.

If the above requirements are not met and the Insured desires to have the newborn covered under the Policy in the future, evidence of the newborn's insurability must be provided at no expense to Us and the newborn must be insurable pursuant to Our then current underwriting guidelines and such Dependent must satisfy the requirements set forth in this Section 3. Coverage shall then take effect on the premium due date coincident with or next following the date on which We approve coverage and premium is paid, if applicable.

Adopted Children

Coverage will be effective for adopted children of the Insured for thirty-one (31) days following placement in the custody of the Insured. Placement means the assumption by the Insured of the physical custody of the adopted child. Coverage shall continue beyond the thirty-one (31) day period provided that the Insured meets the following requirements:

1. makes written request for coverage, on forms approved by Us, within thirty-one (31) days from placement; and
2. makes the required premium payment, if applicable.

If the above requirements are not met and the Insured desires to have the adopted child covered under the Policy in the future, evidence of the adopted child's insurability must be provided at no expense to Us and the adopted child must be insurable pursuant to Our then current underwriting guidelines and such Dependent must satisfy the requirements set forth in this section. Coverage shall then take effect on the premium due date coincident with or next following the date on which We approve coverage and any applicable premium is paid.

Newly Born Infants Adopted by the Insured: If such insured takes custody of the infant upon such infant's release from the hospital and files a petition pursuant to section one hundred fifteen-c of the domestic relations law within thirty days of birth; and provided further that no notice of revocation to the adoption has been filed pursuant to section one hundred fifteen-b of the domestic relations law and consent to the adoption has not been revoked, shall be effective from the moment of birth until such child is 31 days old. Coverage for newly born adopted infants shall be the same as for all other Dependents. You must notify Us in writing within 31 days of such birth, and pay the required additional premium, if any, in order to have the coverage for the newly born adopted infant continued beyond such 31 day period.

Rescission of Insurance

False or missing information on Your enrollment applications may be the basis for rescission of coverage.

Rescission voids the coverage from the Effective Date. This means that no benefits will be paid for any claim submitted. Premiums already paid for the time period for which coverage was rescinded will be refunded less any claim payment adjustment, if any. If coverage is rescinded for any Covered Person, all Policy provisions with respect to that Covered Person are rescinded and become null and void.

SECTION 4 - PREMIUM PAYMENT

Payment Of Premium

Premiums are payable to Us or Our authorized representative. No insurance agent, insurance broker or insurance consultant is authorized to accept any premium payment on Our behalf. You must timely pay the monthly premium in order to maintain the Policy. The payment of any premium will not keep the Policy in force beyond the due date of the next premium, except as provided in the Grace Period. If any premium is not received by Us before or at the end of the Grace Period, the Policy will automatically end at the end of the period for which the last premium payment has been paid.

Grace Period

After payment of the first premium, We will allow a Grace Period of thirty-one (31) days following the premium due date to pay subsequent premiums. Charges incurred during the Grace Period are not covered unless the premium due is paid by the end of the Grace Period. The payment of any premium will not keep the Coverage in force beyond the due date of the next premium. If the premium due is not paid by the end of the Grace Period, then coverage will lapse as of the due date.

Premium Changes

We reserve the right to change premiums, on a class basis, on any premium due date by giving the Insured at least thirty-one (31) days prior written notice.

Reinstatement of Insurance

If Your Certificate lapses due to non-payment of premium, reinstatement of coverage may be considered if You notify Us of Your intention to reinstate. Upon such notice, We will furnish You an application to be completed and submitted along with premiums necessary to pay the Certificate to a current status. Your premium payment and Your completed application for reinstatement must be received by Us within sixty (60) days from the premium due date. Reinstatement will not be effective unless approved by the Company.

SECTION 5 - BENEFITS

We will pay benefits for Covered Procedures; incurred by a Covered Person up to the Maximum Amount shown in the Schedule of Benefits. A Covered Charge is considered incurred on the date the treatment or service is rendered or the supply is furnished. Covered Procedures are subject to the:

- Deductible;
- Co-Insurance;
- Copay
- Calendar Year Maximum Amount;
- Lifetime Maximum Amount; and
- All other Maximums, Limitations, Exclusions and provisions of the Policy.

Date Dental Treatment Begins and Ends

We consider a dental treatment to be started as follows:

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

We consider a dental treatment to be completed as follows:

1. for a full or partial denture, the date a final completed prosthesis is first inserted in the mouth;
2. for a fixed bridge, crown, inlay and onlay, the date the bridge or restoration is cemented in place; and
3. for root canal therapy, the date a canal is permanently filled.

PREDETERMINATION OF BENEFITS

Except in an Emergency, if You need treatment which will cost more than the Predetermination Amount shown on the Schedule of Benefits page, Your Dentist must submit a claim to Us before beginning treatment which describes the treatment necessary and its cost. We have the right to request any additional information We deem necessary to evaluate this claim. This includes, but is not limited to, dental records and X-rays.

We will prepare and return to You and Your Dentist an estimate of the treatment and the amount for which benefits are payable. This estimate is not a guarantee of payment by Us.

We will still consider a claim for which You have not obtained prior approval. These claims will be subject to reduced benefits based on Our determination of Reasonable and Customary Charges and Medically Necessary treatment.

ALTERNATE BENEFITS

There is often more than one service or supply that can be used in treatment. In determining the benefits payable on a claim, different materials and methods of treatment will be considered. The Covered Charges will be limited to the Reasonable and Customary Charge for the least expensive service which meets broadly accepted standards of dental care as determined by Us. If the Covered Person and the Dentist decide on a more expensive procedure or material than We have determined to be satisfactory for the treatment, the benefit payment will be limited to the Reasonable and Customary Charge for the least expensive alternative treatment subject to any Deductible, if any, the Co-Insurance, the Calendar Year Maximum Amount and the Lifetime Maximum Amount. The excess amount will not be paid by Us.

The following treatments, services, or supplies, are some examples of where an excess amount will not be paid by Us:

1. Gold or porcelain, if silver or some other material would be acceptable or appropriate;
2. For partial dentures, any material other than cast chrome or acrylic;
3. Personalized fillings, inlays, or onlays or other restorations;
4. The use of special techniques, if standard techniques would be acceptable or appropriate; or
5. Replacement of a denture or bridge that could have been repaired or modified.

Services Performed Outside the U.S.A.: Any claims submitted for procedures performed outside the U.S.A. must be supplied in English, must use American Dental Association (ADA) codes, and must be in U.S. Dollar currency. Reimbursement will be based on the Reasonable and Customary Charges, Fees or Expenses for Your zip code.

SECOND OPINIONS

If You obtain a second opinion before undergoing treatment, benefits are payable for the cost of this second opinion if:

- the second Dentist is not in practice with the first Dentist and is qualified to render an opinion; and
- You supply the second Dentist with all pertinent X-rays and/or test results from the first Dentist.

Benefits will not be paid for duplicate tests or X-rays.

Benefits payable under this provision are subject to all maximums, limitations, conditions, and exclusions of this Certificate.

SECTION 6 – EXCLUSIONS AND LIMITATIONS FROM COVERAGE

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

1. Treatment, services or supplies which:
 - A. Are not Medically Necessary;
 - B. Are not prescribed by a Dentist;
 - C. Are determined to be Experimental/Investigational in nature by Us unless such service has been recommended for the insured by an external appeal agent upon an appeal;
 - D. Are received without charge or legal obligation to pay;
 - E. Would not routinely be paid in the absence of insurance;
 - F. Are received from any Family Member;
 - G. Are not Covered Procedures.
2. Self-inflicted injuries.
3. War or an act of war, whether or not declared. This exclusion does not include deaths due to disease or accidents that are common to the civilian population and are not attributable to special hazards to which persons serving in the armed forces or attached civilian units are exposed in the line of duty. This exclusion terminates six months after the end of the war in which the insured was engaged or was likely to engage in at the time of application, after the discharge, release or separation of the insured from active military service, after the demobilization of the insured, or after the insured permanently leaves the war area, whichever occurs first.
4. A Covered Person's commission of a felony or an assault on another person.
5. Employment; whether caused by, related to, or as a condition of employment, including self-employment. This exclusion applies even if Workers' Compensation or any Occupational Disease or similar law does not cover the charges.
6. Treatment which began, before the Covered Person's Effective Date of coverage or after the Covered Person's termination of coverage.
7. Congenital or development malformations existing when the Covered Person's coverage became effective under this Certificate.
8. Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
9. Periodontal splinting.
10. Porcelain on crowns, or pontics posterior to the 2nd bicuspid.
11. Replacement of partial or full dentures, fixed bridge work, crowns, gold restorations and jackets more often than once in any 5 year period.
12. Relining of dentures more often than once in any 2 year period.
13. Lost, stolen, or missing dentures or bridges or for duplicates.
14. Fixed or removable bridgework involving replacement of a natural tooth or teeth which was lost prior to the Covered Person's Effective Date of coverage under this Certificate. Benefits may be payable for bridgework required for loss of teeth while covered under this Certificate, if such bridgework is not an abutment for non-covered bridgework.
15. Prescription Drugs and analgesia pre-medication.
16. Dental education or training programs including oral hygiene or plaque control programs.
17. Counseling on diet and nutrition.
18. Military service, including service in a military reserve unit.
19. Charges made by any government entity unless the Covered Person is required to pay; or by any public entity from which coverage could have been obtained by application or enrollment even if application or enrollment was not actually made.
20. Bacteriologic cultures in connection with a covered dental service.
21. Therapeutic injections administered by a Dentist.
22. Medical expenses related to Temporomandibular joint syndrome.
23. Treatment for a Dependent who lives outside the United States.

SECTION 7 – ACCESSING AND ADMINISTERING YOUR BENEFITS

PREFERRED PROVIDER ORGANIZATIONS

Your Coverage includes access to a Preferred Provider Organization (PPO). A Covered Person is free to obtain dental care from the Dentist of his or her choice, but the Covered Person's out-of-pocket expenses may be less in the case of treatment received from an In-Network Provider or an Out-of-Network Provider. The Co-Insurance payable for a Covered Charge is shown in the Schedule of Benefits. Services rendered to a Covered Person by an In-Network or an Out-of-Network Provider are paid under the Policy as shown in the Schedule of Benefits.

Covered Charges incurred in the event of an Emergency, shall be payable under the Schedule of Benefits as an In-Network Provider or an Out-of-Network Provider.

We do not make any representation or warranty as to the medical competence or ability of an In-Network Provider or an Out-of-Network Provider or to their respective staff or Dentists. We shall not have any liability or responsibility, either direct, indirect, vicarious or otherwise, for any actions or inactions, whether negligent or otherwise, of the In-Network Provider or Out-of-Network Provider, their staff or Dentists.

COORDINATION OF BENEFITS

Applicability

1. The following provisions are applied to determine which insurance Plan pays benefits first when a Covered Person is covered by two or more plans. A Plan that pays first is called "primary". All other plans are called "secondary".
2. If these provisions apply, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:
 - A. Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but
 - B. May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described under **"Effect on the Benefits of This Plan."**

Definitions

1. "Plan" is any of these which provides benefits or services for, or because of, dental care or treatment:
 - A. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - B. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act (42 U.S.C.A. 301, et seq.), as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

2. "This Plan" is the part of the group contract that provides benefits for dental care expenses.
3. "Primary Plan/Secondary Plan:" The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

4. "Allowable Expense" means a necessary, reasonable and customary item of expense for dental care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

5. "Claim Determination Period" means a [Calendar Year] [Policy Year]. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

Order of Benefit Determination Rules

1. General. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless;
 - A. The other plan has rules coordinating its benefits with those of This Plan; and
 - B. Both those rules and This Plan's rules, in Subsection B below, require that This Plan's benefits be determined before those of the other plan.

2. Rules. This Plan determines its order of benefits using the first of the following rules which applies:

- A. Non-Dependent/Dependent. The benefits of the plan which covers the person as a member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, Medicare is

- i. Secondary to the plan covering the person as a dependent; and
 - ii. Primary to the plan covering the person as other than a dependent.

- B. Dependent Child/Parents not Separated or Divorced. Except as stated in subsection (B)(3) below, when This Plan and another plan cover the same child as a dependent of different person, called "parents":

- i. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
 - ii. If both parents have the same birthday, the benefits of the plan which covered the parents longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in subsection (2)(a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- C. Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- i. First, the plan of the parent with custody of the child;

- ii. Then, the plan of the spouse of the parent with the custody of the child; and
- iii. Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the dental care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- D. **Dependent Child/Joint Custody.** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph III subsection B(2) above.
- E. **Active/Inactive Employee.** The benefits of a plan which covers a person who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (4) is ignored.
- F. **Continuation coverage.** If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:
 - i. First, the benefits of a plan covering the person as a member or subscriber (or as that person's dependent);
 - ii. Second, the benefits under the continuation coverage.

If the other plan does not contain the order of benefits determination described within this subsection, and if, as a result, the plans do not agree on the order of benefits, this requirement shall be ignored.

- G. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan which covered a member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

Effect on the Benefits of this Plan

- 1. **When This Section Applies.** This Section IV applies when, in accordance with Section III "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in (B) immediately below.
- 2. **Reduction in this Plan's Benefits.** The benefits of This Plan will be reduced when the sum of:
 - A. The benefits that would be payable for the Allowable Expense under This Plan in the absence of this provision; and
 - B. The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this provision, whether or not claim is made;

exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We needs to pay the claim.

Facility of Payment

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. The persons We have paid or for whom We have paid;
2. Insurance companies; or
3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SUBROGATION/RIGHT OF REIMBURSEMENT

As a condition to receiving benefits under this Policy, Covered Person(s) agree to transfer to Us their right to recover damages to the extent of benefits paid by Us when a loss occurs through the act or omission of another person. If a Covered Person received payment from another person or entity on account of, due to, or arising out of a dental injury, the Covered Person agrees to reimburse Us to the full extent of Covered Charges paid. If a repayment agreement is required to be signed, all rights of recovery are transferred to Us regardless of whether it is actually signed. It is only necessary that the dental injury occur through the act or omission of another person or entity. Our rights of full recovery may be from any other person or entity, any liability or other insurance covering such other person or entity party, the Covered Person's own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no-fault, workers compensation or school insurance coverages which are paid or payable. We may enforce Our reimbursement rights by requiring the Covered Person to assert a claim to any of the foregoing coverages to which the Covered Person may be entitled. Covered Person(s) shall provide all requested accident and insurance information to Us. We shall not be required to pay any portion of Covered Person's attorneys' fees or other costs associated with a claim/lawsuit.

SECTION 8 - TERMINATION

Insured's Insurance

The Insured's insurance shall terminate on the earliest of the following dates:

1. The date of termination of the Policy ;
2. The next premium due date after We receive Your written request to terminate coverage of the Insured Person under the Policy;
3. The last premium due date prior to a grace period, if the premium then due is not paid within the grace period;
4. The date the Insured Person has been determined by Us to have committed an act of fraud or made an intentional misrepresentation of material fact under the terms of the Policy;
5. The date the Insured reaches the Maximum Benefit while covered under the Policy as specified in the Schedule of Benefits; or
6. The date of Your death.

Dependent Insurance

The insurance coverage of a Dependent shall terminate on the earliest of the following dates:

1. The date of termination of the Policy;
2. The next premium due date after We receive Your written request to terminate coverage of the Dependent under the Policy;
3. The premium due date coinciding with or next following the date on which a Dependent ceases to meet the definition of Dependent;
4. The date the Dependent has been determined by Us to have committed an act of fraud or made an intentional misrepresentation of material fact under the terms of the Policy;
5. The date the Dependent reaches the Maximum Benefit while covered under the Policy as specified in the Schedule of Benefits; or
6. The date of the Dependent's death.

The attainment of the limiting age by a covered Dependent will not cause coverage to terminate while that person is and continues to be both incapable of self-sustaining employment by reason of Mental or Physical Incapacity and Chiefly Dependent on You for support and maintenance.

"Chiefly Dependent" means the covered Dependent receives the majority of his/her financial support from You. If a covered Dependent is handicapped beyond the limiting age and You desire continued coverage for Your covered Dependent, You must provide written proof that the covered Dependent is Chiefly Dependent, at least thirty-one (31) days prior to the date upon which the covered Dependent would otherwise reach the limiting age. Thereafter, We may request such proof no more frequently than annually. In the absence of such proof, We may terminate the coverage of such person after the attainment of the limiting age.

SECTION 9 - GENERAL PROVISIONS

Entire Contract

The entire contract is made up of: (a) the Policy; (b) the application of the Policyholder; (c) the applications of the Insured Persons for coverage under the Policy; and (c) any subsequent amendment, rider or endorsement to the Policy.

No agent, Insured Person or other individual, except Our President, Vice President, Secretary or Assistant Secretary, can extend the time for payment of any premium. A change to the Policy which requires the Policyholder's consent will be valid only if signed by the Policyholder and Our President, Vice President, Secretary or Assistant Secretary. A change to the Certificate which requires Your consent will be valid only if signed by You and Our President, Vice President, Secretary or Assistant Secretary. A change to the Policy or a Certificate which does not require the consent of the Policyholder or You will be valid only if signed by Our President, Vice President, Secretary or Assistant Secretary. No changes in the Group Policy will invalidate or impair any rights granted to the certificateholder in the certificate.

Contestability

In the absence of fraud, statements made by an Insured Person are representations and not warranties. After the Insured Person has been covered under the Policy for two consecutive years, only fraudulent misstatements in the application may be used to void coverage under the Policy or deny any claim for loss incurred after the 2-year period. If a Covered Person's age was misstated, We will provide the amount of insurance for the correct age and an equitable premium adjustment will be made so that We will receive the correct premium for the true age.

Misstatement of Age or Sex

If an Covered Person's age and/or sex was misstated, We will provide the amount of insurance for the correct age and/or sex and an equitable premium adjustment will be made so that We will receive the correct premium for the true age and/or sex.

Notice of Claim

Written notice of claim must be given to Us: (a) within 20 days after the date on which the claim was incurred; or (b) as soon as reasonably possible thereafter. Notice can be sent to Our authorized administrator or Our Home Office. The notice should include the Covered Person's name and group policy number.

Proof of Loss

Written proof of loss must be given to Us or Our authorized administrator within 90 days of the date on which the charges are incurred. If it was not possible for proof to be given within the 90 days, We will not deny the charges provided proof is given as soon as reasonably possible. The date on which the charges are incurred is the date on which the services or supplies were provided.

Time of Payment of Claims

Payments for Covered Charges will be paid as they accrue, subject to written proof of loss. Any balance unpaid at the end of liability will be paid on receipt of written proof of loss. Covered Charges paid by the Policy will be paid within 45 days following the date on which Our authorized administrator receives written proof of loss. Covered Charges for claims payable under the Policy are overdue if not paid within 45 days after We, or Our administrator, receives proof of loss and necessary medical information or other information required by Us essential to administer the provisions of the Policy. If such information is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within 45 days. Any part or all of the remainder of the claim that is later supported by such proof is over due if not paid within 45 days.

Payment of Claims

Covered Charges will be payable to the Insured Person unless they are assigned to a Dentist or other health care provider. Any notice of assignment of benefits must be in writing and mailed to Us or Our authorized administrator. Notice of the assignment of benefits received from a Dentist or other health care provider will be sufficient to cause Covered Charges to be paid to such Dentist or other health care provider. You may revoke an assignment of benefits at any time by providing written notice of such revocation to Us or Our authorized administrator. Any such written revocation of an assignment of benefits shall be valid as to both You and the Dentist or other health care provider.

Recovery of Overpayments

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

1. In error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under this Policy within two (2) years after the date such coverage commences; or
4. with respect to an ineligible person; or
5. 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 a Covered Person.

Conformity with Federal and State Laws

Any provision of the Policy which is in conflict with Federal laws or any applicable state law, is hereby amended to meet the minimum requirements of the law.

Legal Action

No legal action may be brought to recover benefits under the Policy prior to the expiration of 60 days after written proof of loss has been furnished. No such action will be brought after the expiration of two years following the date written proof of loss was required to be furnished.

Ambiguities

Any terms or conditions specified in the Policy that are determined as a result of arbitration to be ambiguous or in conflict with State or Federal laws shall be considered separately and shall not void or affect the legality of the remaining terms and conditions that are included in the Policy.

Physical Examination

We have the right, at Our own expense, to have a Covered Person examined as often as is reasonable while a claim is pending.

Certificates/Booklets

We will issue a Certificate for delivery to each Insured Person, which shall not constitute a part of the Policy, but which shall merely state the essential features of the insurance to which each Covered Person is entitled, to whom benefits are payable, and the requirements for payment of benefits.

Waiver Of Rights

If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date; nor will it affect Our right to enforce any other provision of the Policy. Any waiver of rights must be in writing and signed by Our President, Vice President Secretary or Assistant Secretary or an individual authorized by them to agree to such waiver.

Required Information

The Insured Person agrees to provide to Us any information or data that we reasonably request for the proper administration of the Policy including; but not limited to, information pertaining to medical history, medical records, the names of all health care providers from whom a Covered Person has received treatment or services, marriage license, documentation of adoption or placement for adoption, documentation of legal custody of a Dependent, student status information, and treating provider statements.

Effective Date

No insurance under the Policy shall become effective until notice in writing is given to the Insured Person by Us. Issuance of a Certificate with a Schedule of Benefits will be deemed proper notification, provided premium due has been paid in accordance with the terms of the Policy.