

# COMPBENEFITS INSURANCE COMPANY

P. O. Box 8236

Chicago, IL 60680-8236

(800) 342-5209

## CERTIFICATE OF GROUP DENTAL INSURANCE

This certificate outlines the features of the Group Dental Insurance Policy issued to the Policyholder by CompBenefits Insurance Company (hereinafter referred to as "CompBenefits"). Read it carefully to become familiar with Your coverage. In this Certificate, the masculine pronouns include both masculine and feminine gender unless the context indicates otherwise.

Your coverage may be terminated or amended in whole or in part under the terms and provisions of the Policy.

Signed for CompBenefits Insurance Company



---

President

**TABLE OF CONTENTS**

DEFINITIONS ..... 3

BECOMING INSURED ..... 3

    Who Can Be Insured ..... 3

    When You Can Be Insured ..... 4

    When Your Insurance Begins ..... 4

    The Actively At Work Requirement ..... 4

    Insurance For Your Dependents ..... 4

    Who Are Your Eligible Dependents ..... 4

    Coverage For Children Placed For Adoption ..... 5

    When Insurance For Dependents Begins ..... 5

    When Your Insurance Ends ..... 5

    When Your Dependents' Insurance Ends ..... 5

DENTAL BENEFITS ..... 6

    Beginning Date for Treatment or Service ..... 6

    Completion Date for Treatment or Service ..... 6

    Waiting Periods ..... 6

    Benefits Payable ..... 6

    Estimate of Benefits ..... 7

    Maximum Benefits ..... 7

    Benefits After Insurance Ends ..... 7

    Major Restorative Limitations ..... 7

    Exclusions ..... 8

COORDINATION WITH OTHER BENEFITS ..... 8

NOTICE OF CONTINUATION OF GROUP HEALTH COVERAGE RIGHTS (COBRA) ..... 10

GENERAL PROVISIONS ..... 11

    Representations and Warranties ..... 11

    Premium Rates ..... 11

    Grace Period ..... 12

    Termination ..... 12

    Notice and Proof of Claim ..... 12

    Legal Action ..... 12

    Conformity with State Statutes ..... 12

    Time of Payment of Claims ..... 13

    Reinstatement ..... 13

    Time Limit on Certain Defenses ..... 13

    Notice of Independent Contractor Relationship ..... 13

## DEFINITIONS

You will need to know what is meant by certain terms used in this certificate. They are defined below.

“You” and “Your” mean the certificateholder.

“We”, “Our” and “Us” mean CompBenefits.

“Premium Due Date” is the first day of each calendar month.

“Effective Date” means the date the Policy begins.

“Eligibility Date” means the date the employee can become insured as defined under When You Can Be Insured.

“Benefit Year” means the Benefit Year shown on Your Plan Summary Description Form.

“Co-payment” means the amount a Member is required to pay when a Covered Dental Expense is rendered.

“Covered Dental Expenses” means the kinds of expenses for which Dental Benefits can be paid. The services and supplies listed in the Schedule of Benefits are the only charges that are Covered Dental Expenses.

“Covered Dental Injury” means all trauma to a covered person's oral structures due to an accident caused by any sudden, unexpected impact from outside the oral cavity, and all complications arising from that trauma.

“Dental Treatment Plan” means a dentist's report which: (a) itemizes the dental procedures that the dentist will perform; (b) lists the charges for each procedure; and (c) is accompanied by supporting pre-operative x-rays and any other appropriate diagnostic information required by CompBenefits. Related procedures (such as cleaning, root planing, fillings and crowns) will be considered part of the same Dental Treatment Plan even if reported on different claim forms and/or on different dates of service, if they are performed within four months of one another.

“Dentist” means any dental or medical practitioner who: a) is properly licensed and registered in accordance with the laws of the state where he practices; and b) provides services which are within the scope of that license.

“Group” means the aggregate of individuals eligible to be covered under the Policy. Group also refers to the subgroup participating under the Policy for the benefit of its group members.

“Participating Dentist” (Preferred Provider) means those licensed dentists selected and contracted with Us as independent contractors to provide Covered Dental Expenses to Members.

“Member” means You and/or Your covered Eligible Dependents.

“Non-Participating Dentist” (Non-Preferred Provider) means any provider who is NOT under agreement with CompBenefits to provide Covered Dental Expenses to Members.

“Participating Dentists Fee Schedule” (Preferred Provider Fee Schedule) is a schedule of maximum allowable charges that Participating Dentists have agreed to charge for Covered Dental Expenses.

“Policyholder” means the employer Group to whom the Policy has been issued.

## BECOMING INSURED

### *Who Can Be Insured*

All persons who are members of the Group can be insured. You are a member of the Group if:

1. You are an employee of the Policyholder; and
2. You work at least the minimum number of hours per week (as defined by the Policyholder).

If You and Your spouse are members of the Group, either of You may choose to be covered for Dental Benefits:

1. as an employee; or
2. as a dependent.

If one chooses to be covered as a dependent, the other must choose to be covered as an employee.

### ***When You Can Be Insured***

You can be insured on the Effective Date if:

1. You are a member of the Group on that date; and
2. You have completed the initial waiting period, if any, as required by the Policyholder.

If You do not meet the above requirements on Effective Date, Your Eligibility Date will be the Premium Due Date which next follows the date You first become eligible as determined by the Policyholder, or during any open enrollment period as may be determined and approved by CompBenefits.

### ***When Your Insurance Begins***

To be insured under this policy, You must enroll within 31 days of your Eligibility Date. If You enroll and meet the Actively At Work Requirement, Your insurance will begin on the Premium Due Date which is the same as or which next follows the date You enroll.

If You do not enroll within 31 days of Your Eligibility Date, You may not enroll until the next anniversary date of the Policy, or during any open enrollment period as may be determined and approved by CompBenefits.

### ***The Actively At Work Requirement***

To become insured under the Group Policy, You must be actively at work. To be actively at work, You must:

1. be able to do the normal tasks of Your job on a full-time basis for a full work day on the day Your insurance is to begin; and
2. be able to do such tasks at one of Your employer's normal places of business or at a location to which You must travel to do Your job; and
3. not be absent from work because of leave of absence or temporary lay-off.

If You do not meet the above requirements, insurance will begin on the Premium Due Date which is the same as or next follows the day on which You do meet these requirements.

### ***Insurance For Your Dependents***

If You are insured by the Group Policy, You can also insure Your Eligible Dependents. If You and Your spouse are members of the Group, either of You, but not both, may insure Your children who are Eligible Dependents.

### ***Who Are Your Eligible Dependents***

Your Eligible Dependents are:

1. Your spouse, if You are legally married; and
2. Your unmarried children who are:
  - (a) up to the Dependent Age listed in the Schedule of Benefits; or
  - (b) up to the Dependent Maximum Age listed in the Schedule of Benefits, are dependent on You for support, and are attending an accredited educational institute, college or university on a full time basis; or
  - (c) are not capable of self-support due to a mental or physical handicap, subject to the following conditions:

- (1) the child must have become incapable prior to his or her 19th birthday, or the Dependent Maximum Age if a full time student, and must be covered as Your Eligible Dependent when he reaches age 19, or the Dependent Maximum Age if a full time student;
- (2) the child must be chiefly dependent on You for support and maintenance;
- (3) the child must stay unmarried and in the condition described above;
- (4) You must give CompBenefits written proof that the child is incapable within 31 days after his or her coverage would end; and
- (5) You may be required to give proof at a later date that the child is still incapable, but not more than once each year after two years following the first proof.

For purposes of this Policy the following are excluded from insurance coverage:

1. a dependent child who can be insured as an employee of the Group; or
2. a dependent who is on active duty with the armed forces of any country.

#### ***Coverage For Children Placed For Adoption***

A child placed with You for adoption will be an Eligible Dependent for Dental Insurance. Dental Insurance for that child will begin on the earlier of:

1. the date of birth if a petition for adoption is filed within 60 days of the birth of such child; or
2. the date You gain custody of the child under a temporary court order that grants You conservatorship of the child; or
3. the date the child is placed with You for adoption; and additional premium, if any, is paid.

#### ***When Insurance For Dependents Begins***

If You have Eligible Dependents on the day You first become insured, You can enroll them on that day. If You do not have Eligible Dependents on the day You first become insured, but later acquire an Eligible Dependent, You can enroll such Eligible Dependent within 31 days after he/she becomes an Eligible Dependent. Dependent coverage will begin on the next Premium Due Date following the date the Eligible Dependent is enrolled, or the Premium Due Date after which You first acquire an Eligible Dependent. If you do not enroll your Eligible Dependent(s) within 31 days of becoming eligible, You may not enroll them until the next anniversary date of the Policy, or during any open enrollment period as may be determined and approved by CompBenefits.

A child born to You while You are insured will be considered an Eligible Dependent and will automatically be insured for 31 days following the moment of birth or until released from the hospital, whichever is later. If You choose to insure Your newborn, You must enroll the child within 31 days of the date of birth or the date released from the hospital, whichever is later, or coverage for that child will terminate at the end of such period.

#### ***When Your Insurance Ends***

Your insurance will end on the earliest of:

1. The date on which the Group Policy terminates.
2. The last day of the month which follows Your last payment to the cost of Your insurance if You stop Your payments.
3. The last day of the month which follows the date You are no longer a member of the Group.
4. The last day of the month in which Your employment terminates.
5. The date on which You request, in writing, to terminate Your insurance.
6. The day before you enter into any naval, military, air force or any other armed service in any country.

#### ***When Your Dependents' Insurance Ends***

Insurance for Your covered Eligible Dependents will end on the earliest of:

1. the date the Group Policy ends;
2. the date the Group Policy is changed to exclude insurance for Your dependents;

3. the date Your insurance ends; or
4. the date ending the term that insurance is in force because of Your last payment to the cost of insurance for Your dependents if You stop Your payments.

Insurance for any one dependent will end on the last day of the month in which he/she ceases to be an Eligible Dependent.

### **DENTAL BENEFITS**

The Dental Benefits described on the pages that follow apply to Covered Dental Expenses incurred:

1. by You while You are insured; and
2. for a dependent while a covered Eligible Dependent.

Covered Dental Expenses will include only those charges for Covered Dental Expenses that begin and are completed while insured.

#### ***Beginning Date for Treatment or Service***

For benefit determination purposes, the following will define the date on which certain Covered Dental Expenses will begin:

1. for full dentures or partial dentures - on the date the final impression is made;
2. for fixed bridges (including a resin bonded bridge), crowns, inlays, onlays and other laboratory prepared restorations - on the date final preparation of the teeth is completed;
3. for root canal therapy - on the date the pulp chamber is first opened;
4. for periodontal surgery - on the date the surgery is actually performed; and
5. for all other services - on the date the service is performed.

CompBenefits will not pay benefits for any service that started prior to the patient being insured. If a procedure is started before the expiration of the waiting period to which that procedure is subject, no benefit will be payable, even if the procedure is completed after the expiration of the waiting period.

#### ***Completion Date for Treatment or Service***

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

1. for dentures and partial dentures - on the date the final completed appliance is inserted in the mouth. However, no denture or partial denture will be considered completed unless and until it is accepted by the patient;
2. for fixed bridges (including a resin bonded bridge), crowns, inlays, onlays, and other laboratory prepared restorations - on the date that the appliance is permanently cemented in place;
3. for root canal therapy - on the date the canals are permanently filled;
4. for periodontal surgery - on the date the surgery is actually performed; and
5. for all other services - on the date the service is performed.

#### ***Waiting Periods***

Benefits for certain services are payable only after a person has satisfied a waiting period. Waiting periods are identified in the Schedule of Benefits.

#### ***Benefits Payable***

The Member may elect to receive Covered Dental Expenses from either a Participating Dentist or a Non-Participating Dentist of his or her choice. If the Member chooses to receive Covered Dental Expenses from a Participating Dentist, the Member is only responsible for paying the applicable Copayment shown in the Schedule of Benefits to the Participating Dentist at the time services are rendered.

When the Member elects to receive Covered Dental Expenses from a Non-Participating Dentist, payment of benefits are based upon the Participating Dentists Fee Schedule after deduction of the applicable Copayment. The Member may pay the

Non-Participating Dentist in full at the time the service is rendered and then submit to Us an itemized statement of charges. The Member is responsible for the costs and fees associated with Covered Dental Expenses in excess of the Participating Dentists Fee Schedule, the Copayment amount and any services or materials NOT covered by the Policy.

The maximum Covered Dental Expense to be considered for payment will be the most economical procedure, determined by CompBenefits, to accomplish a professionally satisfactory result.

### ***Estimate of Benefits***

If Covered Dental Expenses for a procedure are expected to be more than \$200, CompBenefits recommends You send to CompBenefits a Dental Treatment Plan for the procedure before treatment begins. The Dental Treatment Plan should be accompanied by supporting pre-operative x-rays and any other appropriate diagnostic materials as requested by CompBenefits. CompBenefits will notify You and Your dentist of the benefits payable based upon the Dental Treatment Plan. In determining the amount of benefits payable, consideration will be given to alternate procedures that may accomplish a professionally satisfactory result. If You and Your dentist decide on a more expensive method of treatment than that predetermined by CompBenefits, We will not pay the excess amount.

### ***Maximum Benefits***

The total amount of Dental Benefits that will be paid for one person for expenses, other than orthodontic expenses (if elected and shown in the Schedule of Benefits), incurred in a Benefit Year will not be more than the Benefit Year Maximum amount shown in the Schedule of Benefits.

### ***Benefits After Insurance Ends***

If a procedure starts for You or a dependent and it has not been completed when Dental Benefits end, You or Your dependent will be entitled to benefits for Covered Dental Expenses incurred for that procedure during the three months just after the insurance ends.

### ***Major Restorative Limitations***

The charges for Major Restorative services will be Covered Dental Expenses subject to the following:

1. the denture or partial denture must replace a Natural Tooth extracted while insured for Dental Benefits under this policy;
2. the fixed bridge (including a resin bonded fixed bridge) must replace a Natural Tooth extracted while insured for Dental Benefits under this policy;
3. the replacement of a partial denture, full denture, or fixed partial denture (including a resin bonded bridge), or the addition of teeth to a partial denture if: (a) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (b) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (c) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a Functioning Natural Tooth while insured for Dental Benefits under this policy; or (d) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;
4. the replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations if: (a) replacement occurs at least five years after the initial date of insertion; and (b) they are not serviceable and cannot be restored to function;
5. the replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition; and
6. the replacement of teeth up to the normal complement of 32.

## ***Exclusions***

Benefits will not be paid for:

1. procedures which are not included in the Schedule of Benefits; which are not medically necessary; which do not have uniform professional endorsement; are experimental or investigational in nature; for which the patient has no legal obligation to pay; or for which a charge would not have been made in the absence of insurance;
2. any procedure, service, or supply which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by CompBenefits;
3. crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;
4. appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting;
5. any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite registration, or bite analysis;
6. adult fluoride treatments, athletic mouthguards; myofunctional therapy; infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery; completion of claim forms; exams required by third party; personal supplies (e.g. water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
7. charges for travel time; transportation costs; or professional advice given on the phone;
8. procedures performed by a Dentist who is a member of Your immediate family;
9. any charges, including ancillary charges, made by a hospital, ambulatory surgical center, or similar facility;
10. charges for treatment rendered: (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any member of Your family; or (b) by an employee of the employer of any member of Your family;
11. any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;
12. charges for treatment performed outside of the United States other than for emergency treatment. Benefits for emergency treatment which is performed outside of the United States are limited to a maximum of \$100 (US dollars) per year;
13. the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;
14. treatment for cosmetic purposes. Facings on crowns or bridge units on molar teeth will always be considered cosmetic;
15. any services or supplies which do not meet the standards set by the American Dental Association or which are not reasonably necessary, or customarily used, for dental care;
16. a sickness for which the patient can receive benefits under a workers' compensation act or similar law;
17. an injury that arises out of or in the course of a job or employment for pay or profit; or
18. Non-Participating Dentist's charges to the extent that they are more than the amount that would have been paid to a Participating Dentist for the same service.

## **COORDINATION WITH OTHER BENEFITS**

### **1. APPLICABILITY.**

This Coordination With Other Benefits provision applies to This Plan when You or Your covered dependents have dental care coverage under more than one Plan. "Plan" and "This Plan" are defined below. If this provision applies, 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) will 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 Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in Section 4, Effect on the Benefits of This Plan.

### **2. DEFINITIONS.**

A "Plan" is any group insurance or group type insurance, whether insured or uninsured, which provides benefits for, or because of, dental care or treatment. This also includes 1) group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans; and 2) group coverage under labor-management trustee plans, union welfare plans, employer organization plans, employee benefit organization plans or self insured employee benefit plans. It does not include school accident type coverages, coverage under any governmental plan required or provided by law, or any state plan under Medicaid. Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and coordination applies only to one of the two, each of the parts is a separate Plan.

"This Plan" is the part of the Group Policy that provides Dental Benefits.

"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.

"Allowable Expenses" 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.

"Claim Determination Period" means a Benefit 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 provision or a similar provision takes effect.

### 3. ORDER OF BENEFIT DETERMINATION RULES.

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

- (a) The benefits of the Plan which covers the person as an employee, 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 secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as other than a dependent, then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent. Except in the case of legal separation or divorce (further described below), when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":
  - (1) 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
  - (2) if both parents have the same birthday, the benefits of the Plan which covered the parent 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 immediately above, 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.
- (b) 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:
  - (1) first, the Plan of the parent with custody of the child;
  - (2) then, the Plan of the spouse of the parent with custody of the child; and
  - (3) 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 health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. 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.

- (c) The benefits of a Plan which covers a person as an employee who is neither laid off, retired or continuing coverage under a right of continuation (or as a dependent of the person) are determined before those of a Plan which covers that person as a laid off, retired or continuing coverage (or as a dependent of that person). 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 is ignored.

- (d) If none of the above rules determines the Order of Benefits, the benefits of the Plan which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

#### 4. EFFECT ON THE BENEFITS OF THIS PLAN.

This section applies when, in accordance with Section 3. Order of Benefit Determination Rules, This Plan is a Secondary Plan to one or more other Plans. In the event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the Other Plans".

The benefits of This Plan will be reduced when the sum of:

- (a) the benefits that would be payable for the Allowable Expenses 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 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.

#### 5. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

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

#### 6. FACILITY OF PAYMENT.

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, CompBenefits may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. CompBenefits 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.

#### 7. RIGHT OF RECOVERY.

If the amount of the payments made by CompBenefits are more than should have paid under this provision, CompBenefits may recover the excess from one or more of: (a) the persons for whom payment has been made; (b) insurance companies or other organizations providing benefits under another Plan.

### **NOTICE OF CONTINUATION OF GROUP HEALTH COVERAGE RIGHTS (COBRA)**

If Your insurance terminates in accordance with the other terms of this Policy, it will be reinstated as of the date of termination if You elect to continue the insurance in force as described in this section. You may elect to continue insurance if You are currently insured under this Policy, and if such insurance is terminating due to any of the following Qualified Events:

- 1) Termination of Your employment (for reasons other than gross misconduct).
- 2) Reduction of work hours including lay-off.
- 3) Death of the insured person.
- 4) Divorce or legal separation.
- 5) A child ceases to be a dependent as defined in this Policy.
- 6) The Policyholder files for a Chapter 11 bankruptcy petition, and as a result to this You suffer a loss of coverage under Your retiree coverage.

However, no continuation of coverage will be provided if You are covered under another group dental care plan coincident with or prior to any of the above events occurring. Continuation of insurance will be retroactive to the date of termination.

The maximum continuation of coverage period with respect to a reason described above is:

- 1) 18 months with respect to 1 or 2 above. However, if You are disabled as determined under Title II or XVI of the Social Security Act, then You and any other non-disabled eligible individuals will be eligible for an additional 11 months.
- 2) 36 months with respect to 3, 4 or 5 above.
- 3) With respect to 6 above, lifetime coverage for You, whereas Your Eligible Dependents will be covered until the earlier of a) Your death; or, b) Death of the Eligible Dependent.

If, while insurance is being continued, further events occur which would entitle You to again elect continuation, the total period of continuation may not exceed 36 months from the date the initial continuation commenced, other than the coverage due to bankruptcy filing as described above.

It is Your responsibility to notify the Policyholder of the occurrence of a Qualifying Event other than termination of employment or reduction in work hours. You must notify the Policyholder within 60 days.

It is the responsibility of the Policyholder to provide You with written notice of Your right to continue coverage under this Section. Such notice will also contain the amount of monthly premium You must pay to continue coverage and the time and manner in which such payments must be made.

To continue coverage under this Policy You must notify the Policyholder of Your election within 60 days of the latest of:

- a) the date of the Qualifying Event;
- b) the date of the loss of coverage; or
- c) the date the Policyholder sends notice of the right to continue coverage.

Payment for the cost of insurance for the period preceding the election must be made to the Policyholder within 45 days after the date of such election. Subsequent payments are to be made to the Policyholder in the manner described by the Policyholder in the notice. The Policyholder will remit the payments to CompBenefits.

Continuation of insurance will terminate at the earliest of the following dates:

- 1) The end of the maximum continuation of coverage period.
- 2) The last day of the period of coverage for which premiums have been paid, if You fail to make a premium payment when due.
- 3) Your becoming covered under another group dental care plan as an employee, spouse or dependent child; however, coverage will continue for a pre-existing condition for which treatment has already commenced and which is excluded or limited by the other group dental plan.
- 4) Discontinuance of this Dental Care Benefit Provision.
- 5) The date Your employer ceases to provide any group dental plan.

## **GENERAL PROVISIONS**

### ***Representations and Warranties***

In the absence of fraud, all statements made by the Policyholder or by an insured person shall be deemed representations and not warranties. No statement made for the purpose of effecting insurance shall avoid the insurance or reduce benefits unless contained in a written instrument signed by the Policyholder or You, a copy of which has been furnished to the Policyholder or You or Your beneficiary.

### ***Premium Rates***

All premiums are payable in advance for coverage under the Policy in accordance with the premium rate schedules of CompBenefits in effect for each Premium Due Date. Premiums are payable to CompBenefits or Our authorized agent. Premiums may be increased for a contract period on the anniversary date of the contract. Notice of the maximum amount of a premium increase will be mailed to the Policyholder not less than 60 days prior to the anniversary of the contract period.

### ***Grace Period***

Unless the Policy is terminated, a grace period of 31 days is allowed for payment of each premium due after the first premium. If any premium is not paid prior to the end of the grace period, the coverage to which the premium applies will lapse at the end of the grace period. We will be entitled to collect all pro rata premiums then unpaid for the period any coverage under the Policy remained in force during such grace period.

### ***Termination***

This Policy may be terminated if CompBenefits elects to discontinue offering this type of group insurance coverage or if CompBenefits elects to discontinue all types of coverage, in accordance with applicable state and federal laws. Except for nonpayment of the required premium or the failure to meet continued underwriting standards, CompBenefits will not terminate this Policy prior to the first anniversary date of the Effective Date of the Policy as specified herein. A notice of termination will be mailed to the Policyholder not less than 60 days prior to the effective date of the termination of the Policy. Termination by CompBenefits will be without prejudice to any expenses originating prior to the effective date of termination.

This section does not apply to a termination for nonpayment of premium by the Policyholder. In the event that the Policyholder fails in a timely manner to pay premiums, the Policy will terminate on the last date for which premium was paid.

### ***Notice of Claim***

Written notice of claim must be given to Us within 20-days after the occurrence or commencement of loss covered by the Policy, or as soon thereafter as reasonably possible. Notice given by or on behalf of You or Your beneficiary to Us at P.O. Box 8236, Chicago, IL 60680-8236, or to Our authorized agent, with information sufficient to identify the Insured, shall be deemed notice to Us.

### ***Claim Forms***

You can get the forms You need for claiming benefits by calling Us at (800) 342-5209 or writing Us P.O. Box 8236, Chicago, IL 60680-8236. If the forms are not sent to You before the expiration of 10 working days after the giving of notice, You shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

### ***Proof of Loss***

Written proof of loss must be furnished to Us at P.O. Box 8236, Chicago, IL 60680-8236 in the case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss within 30-days after the termination period for which We are liable and, in the case of claim for any other loss, within 90-days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is 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.

### ***Legal Action***

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

### ***Conformity with State Statutes***

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

### ***Time of Payment of Claims***

All benefits payable under the policy will be payable immediately upon receipt of due written proof of such loss. Should We fail to pay the benefits payable under the policy, upon receipt of due written proof of loss, We shall have 15 working days thereafter within which to mail the You a letter or notice which states the reasons We may have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have 15 working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

We shall pay interest to the insured equal to 18 percent per annum on the proceeds or benefits due under the terms of the policy for failure to comply with the requirements of the above paragraph.

In the event We fail to pay benefits when due, the person entitled to such benefits may bring action to recover such benefits, any interest which may accrue as provided above and any other damages as may be allowable by law.

### ***Reinstatement***

If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by CompBenefits or by any agent duly authorized by CompBenefits to accept such premium without requiring in connection therewith an application for reinstatement shall reinstate the policy; provided, that if CompBenefits or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by CompBenefits, or lacking approval, upon the forty-fifth day following the date of such conditional receipt unless CompBenefits has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects, the insured and CompBenefits shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

### ***Time Limit on Certain Defenses***

In the absence of fraud all statements made by the Policyholder or You shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall avoid the insurance or reduce benefits unless contained in a written instrument signed by the Policyholder or You, a copy of which has been furnished to the Policyholder or to You or Your beneficiary;

After this policy has been in force for a period of two (2) years and in the absence of fraud, it shall become incontestable as to the statements contained in the application.

### ***Notice of Independent Contractor Relationship***

CompBenefits assumes responsibility of fulfilling the terms of this Certificate. Participating Dentists are independent contractors, and CompBenefits cannot be held responsible for any damages incurred as a result of tort, negligence, breach of contract, or malpractice by a Participating Dentist for any damage which result from any defective or dangerous condition in or about any facility which services are rendered or materials are provided hereunder.