1032654

01/01/2013

**GROUP POLICY FOR:**

# MARTIN TRANSPORTATION SYSTEMS, INC.

## MEMBERS ELECTING LOW PLAN

**Group Voluntary Dental Preferred Provider Organization (PPO) Insurance**

**Print Date: 03/01/2013**

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**CHANGE NO. --1-- AMENDMENT TO BE ATTACHED TO AND MADE A PART OF PRINCIPAL LIFE INSURANCE COMPANY GROUP POLICY NO. VDP 1032654 ISSUED TO**

**MARTIN TRANSPORTATION SYSTEMS, INC.**

It is agreed that the above Group Policy be amended effective as of January 1, 2013, by striking all pages and replacing such pages with the following updated Group Policy.

The effect of this change is to completely replace the documentation of the contract between the above-named Policyholder and The Principal. Therefore, as of the effective date of this change, all prior versions of that documentation are null and void. This change is not intended to renew the contract between the Policyholder and The Principal in any way which affects the time limits of the coverages or limitations as stated in the original documentation.

The provisions and conditions set forth on any attached page are part of this Amendment the same as if set forth above.

This Amendment will become effective as a Written agreement between The Principal and the Policyholder on the first premium due date following the effective date shown above for which premium due under this Group Policy is received by The Principal.

Executed by The Principal as of February 28, 2013.

Joyce N. Hoffman
Senior Vice President and Corporate Secretary

Larry Zimpleman
President and Chief Executive Officer

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**PRINCIPAL LIFE INSURANCE COMPANY**
**(called The Principal in this Group Policy)**
**Des Moines, Iowa 50392-0001**

This group insurance policy is issued to:

MARTIN TRANSPORTATION SYSTEMS, INC.
(called the Policyholder in this Group Policy)

The Date of Issue is January 1, 2013.

In return for the Policyholder's application and payment of all premiums when due, The Principal agrees to provide:

**MEMBER AND DEPENDENT**

**GROUP VOLUNTARY DENTAL EXPENSE INSURANCE**

**PREFERRED PROVIDER ORGANIZATION (PPO) PLAN**

subject to the terms and conditions described in this Group Policy.

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Senior Vice President and Corporate Secretary

President and Chief Executive Officer

GROUP POLICY NO. VDP 1032654
NONPARTICIPATING
CONTRACT STATE OF ISSUE: MICHIGAN

**This policy has been updated effective January 1, 2013**

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## PART I - DEFINITIONS

When used in this Group Policy, the terms listed below will mean:

**Accidental Injury**

An injury to the natural teeth that results solely from accidental means (excluding any injury that occurs from chewing).

**Active Work; Actively At Work**

The active performance of all of a Member's normal job duties at the Policyholder's usual place or places of business.

**Benefit Waiting Period**

The period of time that must pass before an individual or a group is covered for specific benefits under this Group Policy. This benefit waiting period is further described in PART III, Section B, Article 3.

**Calendar Year**

January 1 through December 31 of each year.

**Covered Charges**

A Treatment or Service is considered to be a Covered Charge if the Treatment or Service is prescribed by a Dentist and is determined by The Principal to be:

a. necessary and appropriate;

b. Generally Accepted.

**Date of Issue**

The date this Group Policy is placed in force: January 1, 2013.

**Deductible; Deductible Amount**

A specified dollar amount of Covered Charges that must be incurred by the Member or Dependent before benefits will be payable under this Group Policy for all or part of the remaining Covered Charges during the Calendar Year.

**This policy has been updated effective January 1, 2013**

**Dental Charges Database (DCD)**

A commercially available dental charge information database selected by The Principal that provides historical information about the charges of dental care providers by procedure code and geographic categories, all as determined and adjusted by the database supplier. The Dental Charges Database will be updated by The Principal as information becomes available from the database supplier, up to twice each year. The Principal may also modify the database at its discretion to reflect its own experience. The Principal has discretion to substitute or replace the selected database with a database or databases of comparable purpose, including a database using information of The Principal only, as determined and adjusted by The Principal, with or without notice. When there is minimal data available, as determined by The Principal, from the DCD for a Treatment or Service, The Principal will determine the Prevailing Charge by calculating the unit cost for the applicable Treatment or Service category using the DCD and multiplying by the relative value of the Treatment or Service based upon a relative value scale selected by The Principal. When considering a complex Treatment or Service or a Treatment or Service that is a new procedure or otherwise does not have a relative value that is applicable, The Principal will assign one. The determination of the Prevailing Charge does not take into account the Non-Preferred Provider's training, experience or category of licensure.

**Dental Hygienist**

A person who works under the supervision of a Dentist and is licensed to practice dental hygiene.

**Dental Treatment Plan**

A Dentist's report of proposed dental treatment which:

a. is in Writing; and

b. lists the procedures required for the Period of Dental Treatment; and

c. shows the charges for each procedure; and

d. is accompanied by any diagnostic materials The Principal might request.

**Dentist**

a. A person licensed to practice dentistry; and

b. a licensed Physician who provides dental Treatment or Service.

**Dependent**

**This policy has been updated effective January 1, 2013**

a. A Member's spouse, if that spouse:

(1) is not in the Armed Forces of any country; and
(2) is not insured under this Group Policy as a Member.

b. A Member's Dependent Child (or Children) as defined below.

**Dependent Child; Dependent Children**

a. A Member's natural or legally adopted child, if that child:

(1) is not in the Armed Forces of any country; and
(2) is not insured under this Group Policy as a Member; and
(3) is less than 26 years of age.

b. A Member's stepchild, if that child:

(1) meets the requirements in a. (1), (2), and (3) above; and
(2) receives principal support from the Member.

c. A Member's foster child, if that child:

(1) meets the requirements in a. (1), (2), and (3) above; and
(2) lives with the Member; and
(3) receives principal support from the Member; and
(4) is under legal guardianship of the Member or Member's spouse; and
(5) is approved in Writing by The Principal as a Dependent Child.

Dependent Child will include any child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to this Group Policy, provided the child meets this Group Policy's definition of a Dependent Child.

**Developmental Disability**

A Dependent Child's substantial handicap, as determined by The Principal, which:

a. results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and

b. is diagnosed by a Physician as a permanent or long term continuing condition.

**Emergency Treatment**

Any Treatment or Service, as determined by The Principal, which is rendered as the direct

**This policy has been updated effective January 1, 2013**

result of an unforeseen occurrence or combination of circumstances which requires immediate, urgent action or remedy.

**Experimental or Investigational Measures**

Any Treatment or Service, regardless of any claimed therapeutic value, not Generally Accepted by a specialist in that particular field of dentistry, as determined by The Principal.

**Full-Time Employee**

Any person, residing in the United States, who is a U.S. citizen or is legally working in the United States, who is regularly scheduled to work for the Policyholder for at least 30 hours a week. The employee must be compensated by the Policyholder and either the employer or employee must be able to show taxable income on federal or state tax forms. Work must be at the Policyholder's usual place or places of business or at another place in which an employee performs his or her regular duties. A person is considered to be residing in the United States if his or her main home or permanent address is in the United States or if the person is in the United States for six months or more during any 12-month period.

An owner, proprietor, or partner of the Policyholder's business will be deemed to be an eligible employee for purposes of this Group Policy, provided he or she is regularly scheduled to work for the Policyholder for at least 30 hours a week and otherwise meets the definition of Full-Time Employee.

**Full-Time Student**

A Member's Dependent Child attending a school that has a regular teaching staff, curriculum, and student body and who:

a. attends school on a full-time basis, as determined by the school's criteria; and

b. is dependent on the Member for principal support.

**Generally Accepted**

Treatment or Service which is the subject of the claim that:

a. has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed dental and scientific literature; and

b. is in general use in the relevant dental community; and

c. is not under scientific testing or research.

**This policy has been updated effective January 1, 2013**

**Group Policy**

The policy of group insurance, issued to the Policyholder by The Principal, which describes benefits and provisions for insured Members and Dependents.

**Harmful Habit Appliances**

Appliances, either fixed or removable, used to train or remind a patient to avoid thumb sucking or tongue thrusting (does not include treatment for bruxism - clenching or grinding of the teeth).

**Immediate Family**

An insured person's spouse, natural or adoptive parent, natural or adoptive child, sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild or spouse of grandparent or grandchild.

**Insurance Month**

Calendar month.

**Lapse in Coverage**

Any break in coverage during which a person is not covered under another group dental expense coverage, including but not limited to any Policyholder benefit waiting period. Continuation provided under COBRA or any state required continuation will not be considered a break in coverage.

**Member**

Any PERSON ELECTING LOW PLAN who is a Full-Time Employee of the Policyholder.

**Non-Preferred Provider/Non-PPO Provider**

A Dentist not contracted with the Dental Preferred Provider Organization (PPO) network identified by The Principal to this Group Policy.

**Orthodontic Treatment or Service**

Any Treatment or Service for:

a. straightening of teeth, formal, full-banded retention and treatment, including x-rays and other diagnostic procedures; and

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b. removable or fixed appliances for tooth or bony structure guidance or retention.

**Period of Dental Treatment**

All sessions of dental care that result from the same initial diagnosis and any related complications.

**Physical Handicap**

A Dependent Child's substantial physical or mental impairment, as determined by The Principal, which:

a. results from injury, accident, congenital defect, or sickness; and

b. is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.

**Physician**

A licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.).

**Placement for Adoption; Placement**

The assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

**Policy Anniversary**

January 1, 2014, and the same day of each following year.

**Policyholder**

The entity to whom this Group Policy is issued (see Title Page).

**Preferred Provider/PPO Provider**

A Dentist contracted with a Dental Preferred Provider Organization (PPO) network identified by The Principal to this Group Policy.

The Policyholder participating in a PPO network does not mean that the insured person's choice of provider will be restricted. The insured person may seek needed dental care from any Dentist of his or her choice. However, in order to avoid higher charges and reduced benefit payment, the insured persons are urged to obtain such care from Preferred Providers whenever possible. Preferred Providers are reimbursed on a fee-for-service basis.

**This policy has been updated effective January 1, 2013**

The Principal has the right to terminate the Preferred Provider Organization (PPO) portion of this Group Policy if The Principal or the Preferred Provider Organization (PPO) terminates the arrangement.

The Principal also has the right to identify different preferred provider organizations from time to time, and to terminate the designation of any Preferred Provider at any time.

**Prevailing Charges**

a. For dental care received from Preferred Providers, the negotiated fee between the Preferred Provider and the PPO.

b. For dental care received from Non-Preferred Providers, the amount that most dental care providers charge within a geographic cost area for a Treatment or Service.

For dental care received from Non-Preferred Providers, the actual cost charged for a Treatment or Service will be in excess of Prevailing Charges, but only to the extent that the actual cost charged exceeds the 90th percentile identified on the Dental Charges Database (DCD). Non-Preferred Providers may charge the Member or Dependent the difference between the actual cost charged and the Prevailing Charge.

**Prior Plan**

The group dental expense coverage of the Policyholder for which this Group Policy is a replacement.

**Second Opinion**

An opportunity to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed Treatment or Service to assess the clinical necessity and appropriateness of the proposed service.

**Second Opinion Consultation Charges**

Covered Charges for:

a. consultation with a Second Opinion Physician to obtain a Second Opinion prior to a Treatment or Service for which a Second Opinion is recommended; and

b. necessary diagnostic, x-ray or laboratory examinations performed in connection with such consultation.

**Second Opinion Physician**

A Physician or Dentist who is:

**This policy has been updated effective January 1, 2013**

a. an appropriate specialist for the particular Treatment or Service recommended; and

b. not a partner or associate of the Physician or Dentist who recommended or will perform the Treatment or Service.

**Signed or Signature**

Any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by The Principal.

**Treatment or Service**

When used in this Group Policy, the term "Treatment or Service" will be considered to mean "treatment, service, substance, material, or device."

**Written or Writing**

A record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

**This policy has been updated effective January 1, 2013**

## PART II - POLICY ADMINISTRATION

### Section A - Contract

**Article 1 - Entire Contract**

This Group Policy, the current Certificate, the attached Policyholder application, and any Member applications make up the entire contract. The Principal is obligated only as provided in this Group Policy and is not bound by any trust or plan to which it is not a signatory party.

**Article 2 - Policy Changes**

Insurance under this Group Policy runs annually to the Policy Anniversary, unless sooner terminated. No agent, employee, or person other than an officer of The Principal has authority to change this Group Policy, and, to be effective, all such changes must be in Writing and Signed by an officer of The Principal.

The Principal reserves the right to change this Group Policy as follows:

a. Any or all provisions of this Group Policy may be amended or changed at any time, including retroactive changes, to the extent necessary to meet the requirements of any law or any regulation issued by any governmental agency to which this Group Policy is subject.

b. Any or all provisions of this Group Policy may be amended or changed at any time when The Principal determines that such amendment is required for consistent application of policy provisions.

c. By Written agreement between The Principal and the Policyholder, this Group Policy may be amended or changed at any time as to any of its provisions.

Any change to this Group Policy, including, but not limited to, those in regard to coverage, benefits, and participation privileges, may be made without the consent of any Member or Dependent.

Payment of premium beyond the effective date of the change constitutes the Policyholder's consent to the change.

**Article 3 - Policyholder Eligibility Requirements**

**This policy has been updated effective January 1, 2013**

To be an eligible group and to remain an eligible group, the Policyholder must:

a. be actively engaged in business for profit within the meaning of the Internal Revenue Code, or be established as a legitimate nonprofit corporation within the meaning of the Internal Revenue Code; and

b. make at least the level of premium contributions required for insurance on its eligible Members. The Policyholder must contribute no more than 50% of the required premium for all Members (including disabled Members, if any); and

c. maintain the greater of 20% participation or five participants with respect to eligible employees; and

d. insure ten or more Members for Member Dental Expense Insurance in order to elect orthodontia.

If a Policyholder had prior coverage with The Principal which coverage terminated due to nonpayment of premium, fraud or misrepresentation of material fact or failure to comply with minimum participation or employer contribution requirements, The Principal will not accept application from that Policyholder within 12 months after the date of such termination.

**Article 4 - Policy Incontestability**

In the absence of fraud, after this Group Policy has been in force two years, The Principal may not contest its validity except for nonpayment of premium.

**Article 5 - Individual Incontestability and Eligibility**

All statements made by any individual insured under this Group Policy will be representations and not warranties. In the absence of fraud, these statements may not be used to contest an insured person's insurance unless:

a. the insured person's insurance has been in force for less than two years during the insured's lifetime; and

b. the statement is in Written form Signed by the insured person; and

c. a copy of the form which contains the statement is given to the insured or the insured's beneficiary at the time insurance is contested.

However, these provisions will not preclude the assertion at any time of defenses based upon the person's ineligibility for insurance under this Group Policy or upon the provisions of this Group Policy. In addition, if an individual's age is misstated, The Principal may at any time

**This policy has been updated effective January 1, 2013**

adjust premium and benefits to reflect the correct age.

The Principal may at any time terminate a Member's or Dependent's eligibility under this Group Policy:

a. in Writing and with 31-day notice, if the individual submits any claim that contains false or fraudulent elements under state or federal law; or

b. in Writing and with 31-day notice, upon finding in a civil or criminal case that a Member or Dependent has submitted claims that contain false or fraudulent elements under state or federal law; or

c. in Writing and with 31-day notice, when a Member or Dependent has submitted a claim which, in good faith judgment and investigation, a Member or Dependent knew or should have known contains false or fraudulent elements under state or federal law.

**Article 6 - Information to be Furnished**

The Policyholder must, upon request, give The Principal all information needed to administer this Group Policy. If a clerical error is found in this information, The Principal may at any time adjust premium to reflect the facts. An error will not invalidate insurance that would otherwise be in force. Neither will an error continue insurance that would otherwise be terminated.

The Principal may inspect, at any reasonable time, all Policyholder records which relate to this Group Policy.

**Article 7 - Certificates**

The Principal will give the Policyholder Certificates for delivery to insured Members. The delivery of such Certificates will be in either paper or electronic format. The Certificates will be evidence of insurance and will describe the basic features of the benefit plan. They will not be considered a part of this Group Policy.

**Article 8 - Workers' Compensation Not Affected**

This Group Policy is not in place of and does not affect nor fulfill the requirements for Workers' Compensation Insurance.

**Article 9 - Dependent Rights**

**This policy has been updated effective January 1, 2013**

**PART II - POLICY ADMINISTRATION**

A Dependent will have no rights under this Group Policy except as set forth in PART III, Section D, Article 2.

**Article 10 - Electronic Transactions**

Any transaction relating to this Group Policy may be conducted by electronic means if performance of the transaction is consistent with applicable state and federal law.

Any notice required by the provisions of this Group Policy given by electronic means will have the same force and effect as notice given in writing.

**Article 11 - Value Added Service**

The Principal reserves the right to offer or provide to a Policyholder a vision discount plan or any other value added service for the employees of the Policyholder. In addition, The Principal may arrange for third party service providers (i.e., optometrists, health clubs), to provide discounted goods and services to those Policyholders of The Principal. While The Principal has arranged these goods, services, and third party provider discounts, the third party service providers are liable to the Members for the provisions of such goods and services. The Principal is not responsible for the provision of such goods or services nor is it liable for the failure of the provision of the same. Further, The Principal is not liable to the Members for the negligent provisions of such goods and/or services by the third party service providers.

**This policy has been updated effective January 1, 2013**

## Section B - Premiums

### Article 1 - Payment Responsibility; Due Dates; Grace Period

The Policyholder is responsible for collection and payment of all premium due while this Group Policy is in force. Payments must be sent to the home office of The Principal in Des Moines, Iowa.

The first premium is due on the Date of Issue of this Group Policy. Each premium thereafter will be due on the first of each Insurance Month. Except for the first premium, a Grace Period of 31 days will be allowed for payment of premium. "Grace Period" means the first 31-day period following a premium due date. The Group Policy will remain in force until the end of the Grace Period, unless the Group Policy has been terminated by notice as described in this PART II, Section C. The Policyholder will be liable for payment of the premium for the time this Group Policy remains in force during the Grace Period.

### Article 2 - Premium Rates

The premium rate for each Member insured for Dental Expense Insurance will be:

| | |
|---|---|
| Member Without Dependents | $10.76 |
| Member With Dependent Spouse | $22.52 |
| Member With Dependent Children | $31.02 |
| Member and All Dependents | $47.25 |

If the Policyholder has at least two other eligible group insurance policies underwritten by The Principal, as determined by The Principal, the Policyholder may be eligible for a multiple policy discount.

### Article 3 - Premium Rate Changes

The Principal may change a premium rate on any of the following dates:

a. on any premium due date, if the initial premium rate has then been in force 12 months or more and if Written notice is given to the Policyholder at least 31 days before the date of change; or

b. on any date the definition of Member or Dependent is changed; or

c. on any date that a schedule of insurance or class of insured Members is changed; or

**This policy has been updated effective January 1, 2013**

d. on any premium due date, if the Policyholder has been receiving a multiple policy discount rate and the Policyholder drops below the minimum number of coverages to receive such discount rate.

If the Policyholder has other group insurance with The Principal, and if dental expense coverage is initially added on a date other than the Policy Anniversary and it is more than six months before the next Policy Anniversary, The Principal reserves the right to change the premium rate on the next Policy Anniversary. Written notice will be given to the Policyholder at least 31 days before the date of change.

If the Policyholder agrees to participate in the electronic services program of The Principal and, at a later date elects to withdraw from participation, such withdrawal may result in certain administrative fees being charged to the Policyholder.

**Article 4 - Premium Amount**

The amount of premium to be paid on each due date will be the sum of the premium rates then in effect for all Members then insured.

If a Member is added or a present Member's insurance is increased or terminated on other than the first of an Insurance Month, premium for that Member will be adjusted and applied as if the change were to take place on the first of the next following Insurance Month.

**Article 5 - Contributions from Members**

Members are required to contribute all of the premium for their insurance under this Group Policy.

Members are required to contribute all of the premium for their Dependent's insurance under this Group Policy.

**This policy has been updated effective January 1, 2013**

## Section C - Policy Termination

### Article 1 - Failure to Pay Premium

This Group Policy will terminate at the end of the Grace Period if total premium due has not been received by The Principal before the end of the Grace Period. Failure by the Policyholder to pay the premium within the Grace Period will be deemed notice by the Policyholder to The Principal to discontinue this Group Policy at the end of the Grace Period.

### Article 2 - Termination for Cause

The Principal may terminate this Group Policy for cause by giving the Policyholder 31 days advance notice in Writing, with "cause" defined to be:

a. the Policyholder ceases to be an eligible group as described in this PART II, Section A; or

b. the Policyholder has made a material misrepresentation to or committed an act of fraud against The Principal.

### Article 3 - Termination Without Regard to Cause

The Policyholder may terminate this Group Policy effective on the day before any premium due date by giving Written notice to The Principal prior to that premium due date. The Policyholder's issuance of a stop-payment order for any amounts used to pay premiums for the Policyholder's insurance will be considered Written notice from the Policyholder.

The Principal may terminate this Group Policy without regard to cause by giving the Policyholder 31 days advance notice in Writing.

The Principal may terminate the Policyholder's coverage on any premium due date if the Policyholder relocates to a state where this Group Policy is not marketed, by giving the Policyholder 31 days advance notice in Writing.

### Article 4 - Policyholder Responsibility to Members

If this Group Policy terminates for any reason, the Policyholder must:

a. notify each insured Member of the effective date of the termination; and

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b. refund or otherwise account to each Member all contributions received or withheld from Members for premiums not actually paid to The Principal.

**This policy has been updated effective January 1, 2013**

## Section D - Policy Renewal

### Article 1 - Renewal

Insurance under this Group Policy runs annually to the Policy Anniversary, unless sooner terminated.

While this Group Policy is in force, and subject to the provisions in this PART II, Section C, the Policyholder may renew at the applicable premium rates in effect on the Policy Anniversary.

**This policy has been updated effective January 1, 2013**

## Section A - Eligibility

### Article 1 - Member Dental Expense Insurance

A person will be eligible for Member Dental Expense Insurance on the first of the Insurance Month coinciding with or next following the date the person completes 90 consecutive days of continuous Active Work as a Member.

If a Member elects to waive coverage under this Group Policy because he or she is covered under group dental expense coverage or coverages provided by the Dependent's employer, the date such coverage terminates because the Dependent is no longer eligible under his/her employer's coverage will be considered the date the Member is eligible to request insurance as described in PART III, Section B of this Group Policy.

### Article 2 - Dependent Dental Expense Insurance

A person will be eligible for Dependent Dental Expense Insurance on the later of:

a. the date the person is eligible for Member Dental Expense Insurance; or

b. the date the person first acquires a Dependent.

A Member may elect to waive coverage for his/her Dependent Child until 31 days after the child's third birthday.

If request for coverage is more than 31 days after the Dependent Child's third birthday, benefits will be limited as described in this PART III, Section B, Article 3.

If a Member's Dependent is employed and covered under group dental expense coverage or coverages provided by the Dependent's employer, the date such coverage terminates because the Dependent is no longer eligible under his/her employer's coverage will be considered the date the Member first acquires that Dependent (and any other Dependent who was also covered under such group coverage or coverages).

**This policy has been updated effective January 1, 2013**

## Section B - Effective Dates

### Article 1 - Member Dental Expense Insurance

**a. Actively at Work**

A Member's effective date for Member Dental Expense Insurance will be as explained in this article, if the Member is Actively at Work on that date. If the Member is not Actively at Work on the date insurance would otherwise be effective, such insurance will not be in force until the day of return to Active Work.

This Actively at Work requirement will be waived for Members who:

(1) are absent from Active Work because of a regularly scheduled day off, holiday, or vacation day; and
(2) were Actively at Work on their last scheduled work day before the date of their absence; and
(3) were capable of Active Work on the day before the scheduled effective date of their insurance or change in their insurance, whichever is applicable.

This Actively at Work requirement may also be waived as described in Replacement of a Prior Plan in PART IV, Section C (1), of this Group Policy.

**b. Effective Date**

If a Member is to contribute a part of premium, insurance must be requested in a form approved by The Principal. The effective date of requested insurance will be based on the Member's date of request.

**(1) Request on or before the date eligible or within 31 days after the date eligible**

Insurance will be in force on the first of the Insurance Month coinciding with or next following the date the Member is eligible if request is made on or before the date the Member is eligible or if coverage is requested within 31 days of the date the Member is eligible.

**(2) Request more than 31 days after the date eligible**

Insurance will be in force on the first of the Insurance Month coinciding with or next following the date of the Member's request.

However, benefits will be limited as described under this Section B, Article 3.

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If request for insurance is made more than 31 days after the date an individual is eligible but other than during the Annual Enrollment Period or Special Enrollment Period as described below, insurance for such individual will become effective as described above.

If request for insurance is made more than 31 days after the date an individual is eligible but during an Annual Enrollment Period as described in c. below, insurance for such individual will become effective as described in c. below.

If request for insurance is made more than 31 days after the date an individual is eligible but as a result of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as described in d. below, insurance for such individual will become effective as described in d. below.

If request for insurance is made more than 31 days after the date an individual is eligible but during a Special Enrollment Period as described in e. below, insurance for such individual will become effective as described in e. below.

**(3) Request more than 31 days after the date insurance terminates at the Member's request**

Insurance will be in force on the first of the Insurance Month coinciding with or next following the date of the Member's request.

However, benefits will be limited as described under this Section B, Article 3.

If request for insurance is made more than 31 days after the date an individual is eligible but other than during the Annual Enrollment Period or Special Enrollment Period as described below, insurance for such individual will become effective as described above.

If request for insurance is made more than 31 days after the date an individual is eligible but during an Annual Enrollment Period as described in c. below, insurance for such individual will become effective as described in c. below.

If request for insurance is made more than 31 days after the date an individual is eligible but as a result of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as described in d. below, insurance for such individual will become effective as described in d. below.

If request for insurance is made more than 31 days after the date an individual is eligible but during a Special Enrollment Period as described in e. below, insurance for such individual will become effective as described in e. below.

**c. Annual Enrollment Period**

**This policy has been updated effective January 1, 2013**

An Annual Enrollment Period will be available for any Member or Dependent who failed to enroll:

(1) during the first period in which he or she was eligible to enroll, or during any subsequent Special Enrollment Period, as described in e. below; or
(2) during any previous Annual Enrollment Period.

For any Member or Dependent not previously insured under this Group Policy, the Benefit Waiting Period provisions described in this Section B, Article 3 do not apply during the Annual Enrollment Period.

To qualify for enrollment during the Annual Enrollment Period, the Member or Dependent:

(1) must meet the eligibility requirements described in this Group Policy, including satisfaction of any applicable waiting period; and
(2) may not be covered under an alternate dental expense plan offered by the Policyholder unless the Annual Enrollment Period happens to coincide with a separate open enrollment period established for coverage election.

The Annual Enrollment Period is generally the one-month period immediately prior to the Policy Anniversary date or another period of time requested by the Policyholder and accepted by The Principal. The Annual Enrollment Period is the period from December 1 through December 31.

The effective date for any qualified individual requesting insurance during the Annual Enrollment Period will be on January 1 following completion of the Annual Enrollment Period provided premium has been paid for the requested insurance.

**d. Court Ordered Coverage Under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN): Benefit Waiting Period provisions as described under this Section B, Article 3 will not apply to a Member or Dependent Child if:**

(1) the Member is enrolled (or is eligible to be enrolled but has failed to enroll during a previous enrollment period); and
(2) the Member has failed to enroll the Dependent Child during a previous enrollment period; and
(3) the Member is required by a QMCSO or NMSN as defined by applicable federal law and state insurance laws to provide dental coverage for the Dependent Child.

The request for enrollment:

(1) may be made at any time after the issue date of the QMCSO or NMSN; and
(2) will apply only to the Member and/or Dependent Child(ren) listed in the QMCSO

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or NMSN.

The effective date of the Member's or Dependent Child's insurance:

(1) will be the first of the Insurance Month coinciding with or next following the date of the request for enrollment; and
(2) will not be subject to the Actively at Work provisions described in this section.

A request for enrollment for any Dependent not listed in the QMCSO or NMSN will be subject to the regular effective date provisions of this Group Policy.

**e. Special Enrollment Period**

A Special Enrollment Period, as described below, will be available for a Member or Dependent if enrollment is made after the first period in which the individual was eligible to enroll.

The Special Enrollment Periods are:

(1) Loss of Other Coverage: A Special Enrollment Period will apply to a Member or Dependent if all of the following conditions are met:

(i) the individual (Member or Dependent) was covered under another group dental expense coverage at the time of his or her initial eligibility, and declined enrollment solely due to the other coverage; and
(ii) the other coverage terminated due to loss of eligibility (including loss due to divorce or legal separation, death, termination of employment or reduction in work hours), or, if the other coverage was under COBRA or state continuation provision, due to exhaustion of the continuation); and
(iii) request for enrollment is made within 31 days after the other coverage terminates.

The effective date of insurance will be the first of the Insurance Month coinciding with or next following the date of the request for enrollment provided premium has been paid for the requested insurance.

NOTE: For the purpose of (1) (ii) above:

"Loss of eligibility" does not include:

(i) a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the dental expense coverage); or
(ii) a loss due to a spouse's voluntary termination of his or her dental expense

coverage; or

(iii) a loss due to a spouse's voluntary termination of his or her Dependent dental expense coverage.

(2) Newly Acquired Dependents: A Special Enrollment Period will apply to a Member or Dependent if:

(i) the Member is enrolled (or is eligible to be enrolled but has failed to enroll during a previous enrollment period); and
(ii) a person becomes a Dependent of the Member through marriage, birth, adoption or Placement for Adoption; and
(iii) request for enrollment is made within 31 days after the date of the marriage, birth, adoption or Placement for Adoption, or the date Dependent Dental Expense Insurance is available to the Member under this Group Policy, if the request is made on or before the event or within 31 days after the event.

The effective date of the Member's or Dependent's insurance will be:

(i) in the event of marriage, the date of such marriage; or
(ii) in the event of a Dependent Child's birth, the date of such birth; or
(iii) in the event of a Dependent Child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption, whichever is earlier.

The Benefit Waiting Period provisions described in this Section B, Article 3 do not apply during the Special Enrollment Period.

**f. Effective Date for Benefit Changes - Change in Member Status**

A change in a Member's Scheduled Benefits because of a change in the Member's status (insurance class) will normally be effective on the first of the Insurance Month coinciding with or next following the date of the change in status. However, if the Member is not Actively at Work on the date a Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the date the Member returns to Active Work.

Any termination of Scheduled Benefits due to a change in a Member's status (insurance class) will be effective on the date of the change in status, whether or not the Member is Actively at Work.

**g. Effective Date for Benefit Changes - Change by Policy Amendment**

A change in the amount of a Member's Scheduled Benefits because of a change in the Schedule of Insurance (as described in PART IV, Section A) by amendment to this Group Policy will be effective on the first of the Insurance Month coinciding with or next following the date of change. However, if the Member is not Actively at Work on

the date a Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the date the Member returns to Active Work.

**h. Effective Date for Benefit Changes - Change in Benefits Made by The Principal**

A change in a Member's Scheduled Benefits because of a change made by The Principal will normally be effective on the Policyholder's Policy Anniversary (or as otherwise determined by The Principal). However, if the Member is not Actively at Work on the date a Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the date the Member returns to Active Work.

**Article 2 - Dependent Dental Expense Insurance**

Dependent Dental Expense Insurance is available only with respect to Dependents of Members currently insured for Member Dental Expense Insurance. If a Member is eligible for Dependent Dental Expense Insurance, such insurance will be effective under the same terms as set forth for Member Dental Expense Insurance in this Section B, Article 1 except:

a. A Member will be insured with respect to a new Dependent on the date the Dependent is acquired, if Dependent Dental Expense Insurance is then in force for any other Dependent of the Member.

b. The Actively at Work requirement will apply only to Member insurance.

**Article 3 - Benefit Waiting Period (for when the Member requests insurance more than 31 days after (1) the date eligible; or (2) the date the Member elects to terminate insurance)**

Other than during an Annual Enrollment Period or a Special Enrollment Period or coverage as required by a QMCSO or NMSN as described in this Section B, Article 1, if the Member requests Member or Dependent insurance more than 31 days after the date the person is eligible under this Group Policy or the Member elects to terminate insurance and more than 31 days later requests to be insured again, benefits payable under this Group Policy will be limited as follows:

a. During the first 12 months, benefits will be payable only for Dental Care Unit 1 (Preventive Procedures) Covered Charges; and

b. During the second 12 months, benefits will be payable only for Dental Care Unit 1 (Preventative Procedures) Covered Charges and Dental Care Unit 2 (Basic Procedures) Covered Charges.

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After insurance has been in force for 24 consecutive months, benefits will be payable for charges incurred for Covered Charges under Dental Care Units 1 and 2.

These Benefit Waiting Period provisions will not apply to Covered Charges incurred for an Accidental Injury that results from an accident that occurred on or after the Member's or Dependent's insurance became effective.

The premium rate charged for insurance under this Benefit Waiting Period provision will be the same as if benefits were not limited.

**This policy has been updated effective January 1, 2013**

## Section C - Individual Terminations

### Article 1 - Member Dental Expense Insurance

Unless continued as provided in Section D - Continuation, a Member's coverage under this Group Policy will terminate on the earliest of:

a. the date this Group Policy is terminated; or

b. the end of the Insurance Month for which the last premium is paid for the Member's insurance; or

c. the end of any Insurance Month desired, if requested by the Member before that date; or

d. the end of the Insurance Month in which the Member ceases to be a Member as defined in PART I; or

e. the end of the Insurance Month in which the Member ceases to be in a class for which Member Dental Expense Insurance is provided; or

f. the end of the Insurance Month in which the Member ceases Active Work.

### Article 2 - Dependent Dental Expense Insurance

Unless continued as provided in Section D - Continuation, a Member's coverage under this Group Policy for a Dependent will terminate on the earliest of:

a. the date his or her Member Dental Expense Insurance terminates; or

b. the date Dependent Dental Expense Insurance is removed from this Group Policy; or

c. the end of the Insurance Month for which the last premium is paid for the Member's Dependent Dental Expense Insurance; or

d. the end of any Insurance Month desired, if requested by the Member before that date; or

e. the end of the Insurance Month in which the Member ceases to be in a class for which Dependent Dental Expense Insurance is provided; or

f. for each spouse or Dependent Child, on the last day of the Insurance Month in which that spouse or Dependent Child ceases to be a Dependent as defined in PART I. However, a spouse who no longer resides with the Member will not cease to be a

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Dependent until legally separated or divorced, provided the spouse otherwise continues to be a Dependent as defined in PART I.

**This policy has been updated effective January 1, 2013**

## Section D - Continuation

### Article 1 - Member Dental Expense Insurance

**a. Sickness or Injury**

If Active Work ends because a Member is sick or injured, insurance for that Member may be continued until the earliest of:

(1) the date insurance would otherwise cease as provided in PART III, Section C; or
(2) the end of the Insurance Month in which the Member recovers; or
(3) the end of the Insurance Month in which the Member is covered under the USERRA continuation provision; or
(4) the end of the Insurance Month after coverage has been continued under this Section for 12 consecutive months.

If coverage under this Group Policy is continued under COBRA, the continuation coverage provided under this subsection will run concurrently with the COBRA continuation.

**b. Layoff or Approved Leave of Absence**

If Active Work ends because a Member is on layoff or approved leave of absence, insurance for that Member may be continued until the earliest of:

(1) the date insurance would otherwise cease as provided in PART III, Section C; or
(2) the end of the Insurance Month in which the layoff or approved leave of absence ends; or
(3) the date the Member becomes eligible for any other group dental expense coverage; or
(4) the date one month after the end of the Insurance Month in which Active Work ends.

If coverage under this Group Policy is continued under COBRA, the continuation coverage provided under this subsection will run concurrently with the COBRA continuation.

### Article 2 - Dependent Dental Expense Insurance

**a. During Continuation of Member Insurance**

Except as otherwise provided in PART III, Section C, Dependent Dental Expense

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Insurance may remain in force during any period that Member Dental Expense Insurance is continued.

**b. Developmentally Disabled or Physically Handicapped Children**

**(1) Qualification**

Dental Expense Insurance for a child may be continued after the child reaches the maximum age for Dependent Children as defined in PART I of this Group Policy, provided that:

- the child is incapable of self-support as the result of a Developmental Disability or Physical Handicap and became so before reaching the maximum age and is dependent on the Member for primary support; and
- except for age, the child continues to be a Dependent Child as defined in PART I; and
- proof of the child's incapacity is sent to The Principal within 31 days after the date the child reaches the maximum age; and
- further proof that the child remains incapable of self-support is provided when The Principal requests; and
- the child undergoes examination by a Physician when The Principal requests. The Principal will pay for these examinations and will choose the Physician to perform them.

**(2) Period of Continuation**

Insurance for a Dependent Child who qualifies as set forth above may be continued until the earlier of:

- the date insurance would cease for any reason other than the child's attainment of the maximum age; or
- the date the child becomes capable of self-support or otherwise fails to qualify as set forth in (1) above.

**Article 3 - Federal Required Continuation**

**a. Consolidated Omnibus Budget Reconciliation Act (COBRA)**

COBRA applies to any employer (except the federal government and religious organizations) that:

(1) maintains group dental coverage; and
(2) normally employed 20 or more employees on a typical business day during the preceding Calendar Year. For this purpose, "employee" means full-time employees

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and full-time equivalent for part-time employees.

Federal law requires that certain group health plans allow qualified persons who would otherwise lose coverage under this Group Policy as a result of a qualifying event, to elect to continue group coverage under this Group Policy. If coverage under this Group Policy is continued under Article 1 or Article 2, above, the continuation coverage provided under COBRA will run concurrently with such continuation provisions.

A full description of the COBRA continuation provisions is included in the administration material provided to the Policyholder and in the booklet-certificate.

**b. Family and Medical Leave Act (FMLA)**

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects this Group Policy. A full description of the FMLA continuation provisions is included in the administration material provided to the Policyholder.

**(1) FMLA and Other Continuation Provisions**

These FMLA continuation provisions:

- are in addition to any other continuation provisions described in this Group Policy, if any; and
- will run concurrently with any other continuation provisions described in this Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

**(2) Eligible Employer**

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding Calendar Year.

**(3) Eligible Employee**

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and
- for at least 1,250 hours during the year preceding the start of the leave; and
- at a worksite where the Eligible Employer employs at least 50 employees within a 75-mile radius.

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For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

**(4) Mandated Unpaid Leave**

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- the birth of a child of an Eligible Employee and in order to care for the child;
- the placement of a child with the Eligible Employee for adoption or foster care;
- to care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition";
- a "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job; or
- because of a "qualifying exigency" arising out of a spouse, son, daughter or parent on active duty or having been notified of a call to active duty.

Eligible Employers are required to allow up to a total of 26 workweeks of unpaid leave during any 12-month period to eligible employees to care for a "covered service member" with a "serious injury or illness".

**(5) Reinstatement**

An Eligible Employee's terminated insurance may be reinstated in accordance with the provisions of the FMLA, subject to the Actively at Work provisions described in PART III, Section B.

**c. Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA)**

Federal law requires that if a Member's insurance would otherwise end because he or she enters into active military duty or inactive military duty for training, the Member may elect to continue insurance (including Dependents insurance) in accordance with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Such continued insurance will terminate on the earliest of:

(1) for a Member and his or her Dependents:

- the date this Group Policy is terminated; or
- the end of the premium period for which premium is paid if the Member fails to make timely payment of a required premium; or
- the date 24 months after the date the Member enters active military duty; or

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- the date after the day in which the Member fails to return to Active Work or apply for reemployment with the Policyholder.

(2) for a Member's Dependents:

- the date Dependent Dental Expense Insurance would otherwise cease as provided in PART III, Section C; or
- the end of any Insurance Month desired, if requested by the Member before that date.

Continuation provisions described in this Group Policy for sickness, injury, layoff, or approved leave of absence, if any, may apply. These continuation provisions, however, will terminate on the end of the Insurance Month in which the Member is covered under the USERRA continuation provision. If the Member qualifies for USERRA or COBRA, the election of one means the rejection of the other.

The reinstatement time period, as provided in this PART III, Section E, may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA. The Actively at Work provision, described in PART III, Section B, will not apply to the reinstated insurance.

This is a general summary of the USERRA and how it affects this Group Policy. A full description of the USERRA continuation provisions is included in the administration material provided to the Policyholder.

## Section E - Reinstatement

### Article 1 - Reinstatement

A Member's terminated insurance will be reinstated if:

a. insurance ceased because of layoff or approved leave of absence; and

b. the Member returns to Active Work for the Policyholder within twelve months of the date insurance ceased.

The Member's reinstated insurance will be in force on the date of return to Active Work. However, the Actively at Work provision discussed in this PART III, Section B, will apply.

Only the period of time during which a Member is actually insured will be included in determining the length of his or her continuous coverage under this Group Policy. For this purpose the period of time during which a reinstated Member's insurance was not in force:

a. will not be considered an interruption of continuous coverage; and

b. will not be used to satisfy any provision of this Group Policy which pertains to a period of continuous coverage.

**This policy has been updated effective January 1, 2013**

## PART IV - BENEFITS

### Section A - Dental Expense Insurance (General Provisions)

### Article 1 - Schedule of Insurance

**a. Insurance Class**

Subject to the Effective Date provisions of PART III, Section B, Scheduled Benefits for Members and Dependents will be:

| Class | Scheduled Benefits |
|---|---|
| All Members and All Dependents | Dental benefits as described in this PART IV, Section B (1), for Covered Charges under Dental Care Units 1 and 2. |

Benefits for Covered Charges under Dental Care Unit 2 will be limited for those Members and Dependents who become insured under the Benefit Waiting Period provision described in PART III, Section B.

**b. Dental Care Units**

Treatment or Service for which benefits are payable under this Group Policy are divided into Dental Care Units:

| | |
|---|---|
| Preventive Procedures | Unit 1 |
| Basic Procedures | Unit 2 |

**c. Maximum Benefits**

Benefit payment provided under this PART IV, Section B (1), for a Member or Dependent will not exceed:

| Covered Charges | Maximum Payment Limit |
|---|---|
| Dental Care Units 1 and 2 | $1,000 each Calendar Year for dental care received from Preferred Providers and $1,000 for Non-Preferred Providers (in combination). |

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Covered Charges used to satisfy the maximum that applies when care is received from PPO Providers will be used in combination with care received from Non-PPO Providers to satisfy the maximum.

**Article 2 - Benefit Qualification**

A Member or Dependent will qualify for payment of the benefits provided for an insurance class if:

a. he or she is insured in that class on the date dental Treatment or Service is received; and

b. the claim requirements of this PART IV, Section C, are satisfied.

**Article 3 - Benefits Payable**

Benefits payable under this Group Policy will be as described in this PART IV, Section B (1), subject to:

a. the limitations listed in this PART IV, Section B (1B); and

b. the terms and conditions set forth in this PART IV, Section D.

**Article 4 - Member Benefit Options**

**a. Benefit Option Election**

A Member may elect to be insured under any of the benefit options offered by the Policyholder. A separate Group Dental Expense Insurance Policy will be issued for each benefit option offered by the Policyholder.

Persons electing coverage under the benefit option provided under this Group Policy will have free choice of providers. However, benefits payable will be reduced if dental care is not received from a PPO Provider.

The benefit option elected by the Member will also apply to the Member's Dependents.

If the Member elects to waive coverage under this Group Policy, he or she will be eligible to apply for coverage under one of the benefit options during the next Annual Enrollment Period as described in PART III, Section B, Article 1. If the Member waives coverage under this Group Policy, coverage is also waived for the Member's

Dependents. In no event will Dependent Dental Expense Insurance be in force for a Member who is not insured for Member Dental Expense Insurance.

Other than during a Special Enrollment Period, the Benefit Waiting Period provisions described in PART III, Section B, Article 3, will apply to a Member and/or Dependent who has previously waived or terminated coverage under this Group Policy if the Member and/or Dependent again requests to be insured under this Group Policy during an Annual Enrollment Period as described in PART III, Section B, Article 1.

**b. Benefit Option Transfer - Applicable only to Members already insured under this Group Policy**

A Member may transfer from one benefit option to another:

(1) during the Annual Enrollment Period designated by the Policyholder for such transfer, provided the Member is already insured under this Group Policy; or
(2) on any premium due date, provided the transfer is requested due to a change in the Member's family status as described below; and the request for the transfer is made in Writing within 31 days after the date the change in family status occurs:

- marriage or divorce;
- death of a spouse or child;
- birth or adoption of a child;
- termination of employment by the Member's spouse or a change in the spouse's employment that causes loss of group coverage;
- the Member's spouse becomes employed;
- the Member's employment or the Member's spouse's employment changes from part-time to full-time or from full-time to part-time;
- the Member or the Member's spouse takes an unpaid leave of absence; or
- the Member's spouse's group dental coverage involuntarily terminates.

Any benefit option transfer will be subject to the following provisions:

(1) Charges for Treatment or Service received by a Member or Dependent while insured under one benefit option may be applied toward satisfaction of the Calendar Year Deductible and maximum payment limit under the other benefit option for the Calendar Year in which the transfer occurs, provided the charges are limited to those that:

- would be Covered Charges under this Group Policy; and
- were not paid under the other benefit option; and
- would have counted toward satisfaction of the Deductible and maximum payment limit under the other benefit option.

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(2) Charges for Treatment or Service received by a Member or Dependent while insured under one benefit option may be counted to determine the payment percentage under the other benefit option for the Calendar Year in which the transfer occurs, provided the charges are limited to those that:

- would be Covered Charges under this Group Policy; and
- were for Treatment or Service received during the Calendar Year in which the benefit option transfer occurred.

(3) Benefits will be payable under each benefit option only for Covered Charges incurred while insured under that particular benefit option.

If a Member is not Actively at Work on the effective date of the transfer, the benefit option in force for the Member before the transfer will continue to apply to the Member until the date of return to Active Work. When the Member returns to Active Work, the new benefit option will then be in force for the Member. The benefit option elected by the Member will also apply to the Member's Dependents.

**This policy has been updated effective January 1, 2013**

## Section B (1) - Dental Expense Insurance (PPO)

### Article 1 - Payment Conditions

If a Member or Dependent receives any Treatment or Service that is listed in this PART IV under the Schedule of Dental Procedures, The Principal will pay the charges for that Treatment or Service. The benefits payable for all listed Treatment or Service received will be as described below.

The total benefit payment for each Member and Dependent will not be more than the Dental Maximum Payment Limit(s).

**a. Preferred Providers**

If dental care is received from Preferred Providers, benefits payable will be:

**(1) Dental Care Unit 1**

100% of Covered Charges each Calendar Year described in this section.

**(2) Dental Care Unit 2**

50% of Covered Charges each Calendar Year in excess of the Deductible Amount described in this section.

**b. Non-Preferred Providers**

If dental care is received from Non-Preferred Providers, benefits payable will be:

**(1) Dental Care Unit 1**

100% of Covered Charges each Calendar Year described in this section.

**(2) Dental Care Unit 2**

50% of Covered Charges each Calendar Year in excess of the Deductible Amount described in this section.

### Article 2 - Deductible Amount

**a. Preferred Providers - Individual**

**This policy has been updated effective January 1, 2013**

If dental care is received from Preferred Providers, the individual Deductible Amount for each Member or Dependent each Calendar Year will be:

(1) none with respect to Covered Charges under Dental Care Unit 1; and
(2) $50 with respect to Covered Charges under Dental Care Unit 2 each Calendar Year.

**b. Preferred Providers - Family Maximum**

If dental care is received from Preferred Providers, the maximum combined Deductible Amount for all persons in the same family (a Member and his or her Dependents) each Calendar Year will be:

(1) none with respect to Covered Charges under Dental Care Unit 1; and
(2) $150 with respect to the combined Member and Dependent total of Covered Charges under Dental Care Unit 2 each Calendar Year; but not counting more than $50 of such Covered Charges for each person in the family.

When the family maximum Deductible is satisfied, benefits will be payable as if the individual Deductibles for each person in the family had been satisfied for the Calendar Year.

**c. Non-Preferred Providers - Individual**

If dental care is received from Non-Preferred Providers, the individual Deductible Amount for each Member or Dependent each Calendar Year will be:

(1) none with respect to Covered Charges under Dental Care Unit 1; and
(2) $50 with respect to Covered Charges under Dental Care Unit 2 each Calendar Year.

**d. Non-Preferred Providers - Family Maximum**

If dental care is received from Non-Preferred Providers, the maximum combined Deductible Amount for all persons in the same family (a Member and his or her Dependents) each Calendar Year will be:

(1) none with respect to Covered Charges under Dental Care Unit 1; and
(2) $150 with respect to the combined Member and Dependent total of Covered Charges under Dental Care Unit 2 each Calendar Year; but not counting more than $50 of such Covered Charges for each person in the family.

When the family maximum Deductible is satisfied, benefits will be payable as if the individual Deductibles for each person in the family had been satisfied for the Calendar Year.

**This policy has been updated effective January 1, 2013**

For each Dental Care Unit, Covered Charges used to satisfy the Deductible that is applicable when care is received from Non-Preferred Providers for the Calendar Year will be counted toward satisfaction of the Deductible that is applicable when care is received from Preferred Providers for the Calendar Year, and vice versa.

In no event will the individual Deductible for combined Preferred Providers and Non-Preferred Providers be more than the Non-Preferred Providers Deductible Amount for the Calendar Year.

**Article 2A - Emergency Treatment**

If a Member or Dependent requires Treatment or Service for Emergency Treatment either within the PPO Service Area or outside the PPO Service Area, and cannot reasonably reach a Preferred Provider, benefits for such Treatment or Service received will be paid as if a Preferred Provider had provided the Treatment or Service.

**Article 3 - Covered Charges**

Covered Charges will be the actual cost charged to the Member or Dependent for Treatment or Service for the listed procedures described in this section under the Schedule of Dental Procedures but only to the extent that the actual cost charged does not exceed Prevailing Charges. Also:

a. if The Principal determines that more than one procedure could be performed to correct a dental condition, Covered Charges will be limited to the Prevailing Charge for the least expensive of the procedures that would provide professionally acceptable results; and

b. Covered Charges will include only those charges for Treatment or Service that begin (see Article 4 below) while the Member or Dependent is insured under this Group Policy; and

c. Covered Charges will include only those charges for Treatment or Service that is completed while the Member or Dependent is insured under this Group Policy, except when the Treatment or Service is covered under the Extended Benefits provision described in Article 5 below.

**Article 4 - Beginning Date for Treatment or Service**

Treatment or Service will be considered to begin on the applicable date shown below:

a. for root canal therapy, on the date the pulp chamber is opened and the pulp canal

explored to the apex; and

b. for all other, on the date the Treatment or Service is performed.

**Article 5 - Extended Benefits**

**a. Applicability**

The Principal will pay Dental benefits for Treatment or Service described in b. below that is received by a Member or Dependent within 30 days after his or her insurance under this Group Policy is terminated, provided that:

(1) the Member or Dependent would have qualified for benefit payment under this section if insurance had remained in force; and
(2) the Treatment or Service began while the Member or Dependent was insured under this Group Policy; and
(3) at the time Treatment or Service is received, this Group Policy is in force.

However, no benefits will be paid for Treatment or Service received on or after the date the Member or Dependent becomes eligible for other group dental expense coverage, unless Written documentation is provided that Treatment or Service began while the Member or Dependent was insured under this Group Policy and the preceding carrier will not provide coverage for the completed Treatment or Service.

**b. Qualified Treatment or Service**

If the requirements of a. above are satisfied, extended benefits will be payable for root canal therapy, but only if the pulp chamber was opened and the pulp canal explored to the apex while the Member or Dependent was insured under this Group Policy.

## Section B (1B) - Dental Expense Insurance - Limitations

### Article 1 - Limitations

Covered Charges will not include and no benefits will be paid for:

a. Treatment or Service that is not a Covered Charge; or

b. the services of any person who is not a Dentist or Dental Hygienist; or

c. any part of a charge for Treatment or Service that exceeds Prevailing Charges; or

d. the services of any person who is in an insured person's Immediate Family; or

e. implants; or

f. Treatment or Service that does not meet professionally recognized standards of quality; or

g. veneers, anterior 3/4 cast crowns, personalization of dentures or crowns (or any other Treatment or Service that is primarily cosmetic); or

h. drugs, medicines, or therapeutic drug injections; or

i. instructions for plaque control, oral hygiene, or diet; or

j. bite registration or occlusal analysis; or

k. Treatment or Service to alter or maintain vertical dimension or restore or maintain occlusion; or

l. Treatment or Service for the purpose of duplicating a prosthetic device or replacing any such device that is lost or stolen; or

m. Treatment or Service for the purpose of duplicating an appliance or replacing any such appliance that is lost or stolen; or

n. Orthodontic Treatment or Service; or

o. Treatment or Service for provisional or permanent splinting; or

p. Treatment or Service for which the Member or Dependent has no financial liability or that would be provided at no charge or at a different charge in the absence of insurance;

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or

q. Treatment or Service that is temporary; or

r. Treatment or Service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or

s. Treatment or Service that results from a sickness that is covered by a Workers' Compensation Act or other similar law; or

t. Treatment or Service that results from an injury arising from or in the course of any employment for wage or profit; except this limitation will not apply to: partners, proprietors, or corporate officers of the Policyholder who are not covered by a Workers' Compensation Act or other similar law; or

u. Treatment or Service that results from war or act of war; or

v. Treatment or Service that results from participation in criminal activities; or

w. Treatment or Service provided outside the United States, unless the Member or Dependent are outside the United States for one of the following reasons:

(1) travel, provided the travel is for a reason other than securing dental care diagnosis or treatment; or
(2) a business assignment, provided the Member or Dependent are temporarily outside the United States; or
(3) Full-Time Student status, provided the student is either:

- enrolled and attending an accredited school in a foreign country; or
- is participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit; or

(4) Mormon missionary work of a Dependent Child; or

x. Treatment or Service replacing tooth structure lost from abrasion, attrition, erosion, or abfraction; or

y. Treatment or Service which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years; or

z. Treatment or Service that is an Experimental or Investigational Measure. (The denial of any claim on the basis of the exclusion of coverage for experimental or investigational Treatment or Service may be appealed through the procedure described in the notice of that claim decision); or

**This policy has been updated effective January 1, 2013**

**PART IV - BENEFITS**

aa. Treatment or Service that is paid for by a Medicare Supplement Insurance Plan; or

ab. Treatment or Service for temporomandibular joint disorders; or

ac. charges by an anesthesiologist for services that were performed in facilities other than a dental office; or

ad. emergency room charges or outpatient facility charges (including but not limited to hospital outpatient facility charges); or

ae. Treatment or Service for patient management (including but not limited to nitrous oxide and analgesia), local anesthetic and general anesthesia and IV sedation, except as otherwise provided in this Group Policy; or

af. Occlusal guards; or

ag. charges that are billed incorrectly or separately for Treatment or Services that are an integral part of another billed Treatment or Service as determined by The Principal.

**This policy has been updated effective January 1, 2013**

## Article 1 - Schedule of Dental Procedures

Unless The Principal agrees otherwise, Covered Charges will include only charges for procedures listed in this PART IV, Section B (2). If a non-listed procedure is accepted, The Principal will determine its maximum allowance based on the Prevailing Charges for a listed procedure of comparable nature.

## Article 2 - Dental Care Unit 1 - Preventive Procedures

Covered Charges will be the actual cost charged to the Member or Dependent for Treatment or Service for the listed procedures described in this article but only to the extent that the actual cost charged does not exceed Prevailing Charges.

**Dental Procedure**

**Examinations**

Only two of the below listed procedures will be covered in any Calendar Year.

Oral examination (evaluation)

Periodic examination (evaluation)

Office visit

Second Opinion

Benefits will be payable for a Second Opinion obtained with respect to a recommended Treatment or Service at 100% of Second Opinion Consultation Charges, subject to Prevailing Charges.

Note: Obtaining a confirming Second Opinion code does not guarantee payment of the Treatment or Service. All other terms, provisions, conditions, limitations, and exclusions of this Group Policy remain in full force and effect with respect to benefits.

**Radiographs**

Full Mouth Survey

**This policy has been updated effective January 1, 2013**

Complete series (including bitewings)
Panoramic

Only one of the listed full mouth surveys will be covered in any 60 consecutive month period.

Bitewing

Only one set will be covered in any Calendar Year.

Occlusal

Only two films will be covered in any Calendar Year.

Periapical

Only four films will be covered in any Calendar Year.

Extraoral X-Rays

Sialography
Cephalometric film
Posterior-anterior or lateral skull and facial bone survey

Only two of the listed extraoral procedures will be covered in any 12 consecutive month period.

Diagnostic x-rays performed in conjunction with root canal therapy or orthodontic treatment will not be considered Unit 1 Covered Charges

**Preventive Services**

Prophylaxis (cleaning of teeth)

Limited to two dental prophylaxis in any Calendar Year. Prophylaxis includes both routine cleaning and periodontal cleaning/maintenance procedures. The periodontal prophylaxis is paid under Unit 2. However, the service applies to the two prophylaxis limit.

Topical application of fluoride

Applicable only to Dependent Children under the age of 15. Only two application(s) will be covered in any Calendar Year.

**This policy has been updated effective January 1, 2013**

Topical application of sealants

Applicable only to first and second permanent molars for Dependent Children under age 15. Covered once each tooth in any 36 consecutive month period.

**This policy has been updated effective January 1, 2013**

## Article 1 - Schedule of Dental Procedures

Unless The Principal agrees otherwise, Covered Charges will include only charges for procedures listed in this PART IV, Section B (3). If a non-listed procedure is accepted, The Principal will determine its maximum allowance based on the Prevailing Charges for a listed procedure of comparable nature.

## Article 2 - Dental Care Unit 2 - Basic Procedures

Covered Charges will be the actual cost charged to the Member or Dependent for Treatment or Service for the listed procedures described in this article but only to the extent that the actual cost charged does not exceed Prevailing Charges.

**Dental Procedure**

**Restorations**

Fillings (amalgam, silicate, plastic, or composite)

Anterior

Mesial-lingual, distal-lingual, mesial-buccal, and distal buccal restorations on anterior teeth will be considered single surface restorations.

Posterior

If multiple posterior restorations involving multiple surfaces with at least one common surface are reported, an allowance will be made for a single restoration reflecting the number of different surfaces.

Multiple restorations provided on the same day, on the same surface of a posterior tooth without involvement of a second surface will be processed as a single surface restoration.

Replacement

Replacement of existing fillings are covered only if at least 24 consecutive months have passed since placement of prior fillings, unless required by new decay in an additional tooth surface.

**This policy has been updated effective January 1, 2013**

Benefits for composite restorations on molar teeth will be based on the benefits for the corresponding amalgam restorations.

Stainless Steel Crown
Prefabricated Resin Crown

For Dependent Children under the age of 19, only one of the listed crowns will be covered in any 24 consecutive month period. If a stainless steel or Prefabricated Resin Crown is used for an adult in lieu of a permanent crown, all replacement restrictions will be as listed for permanent crowns in Section B (4). If a permanent crown replaces a crown listed in this section at a later date but before replacement restrictions allow, all new charges will be reduced by those already paid.

**Periodontic Services**

Full Mouth Debridement

Covered once per lifetime. Only covered if no other service (other than x-rays) is provided during the visit.

Periodontal Prophylaxis (includes probing, charting, polishing, scaling, root planing, and similar maintenance procedures).

Covered only if at least three months have elapsed after completion of covered active therapeutic scaling and root planing or covered active surgical periodontal treatment. Limited to two dental prophylaxis (routine cleaning or periodontal cleaning/maintenance procedure) in any Calendar Year.

Prophylaxis includes both routine cleaning and periodontal cleaning/maintenance procedures. The routine prophylaxis is paid under Unit 1. However, the service applies to the two prophylaxis limit.

**Oral Surgery**

Simple extraction
Surgical removal of erupted tooth
Root removal - exposed roots

There will be no separate benefit payable for bone grafting of an extraction site.

Incision and drainage of dental abscess
Biopsy of soft tissue

**Other Services**

**This policy has been updated effective January 1, 2013**

Emergency Examination (evaluation)

Coverage for Emergency Examination is limited to the frequency limitation described under examination in Dental Care Unit 1.

Consultation with specialist

Covered once in any 12 consecutive month period. Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Antibiotic drug injection

Office visit after regularly scheduled hours

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Palliative treatment

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Harmful Habit Appliance

Limited to one time per person under age 15.

Space Maintainers

Applicable only to Dependent Children under age 15. Repairs to space maintainers are not covered. Limited to one bilateral space maintainer per arch or one unilateral space maintainer per quadrant.

**This policy has been updated effective January 1, 2013**

## Section C - Claim Procedures

### Article 1 - Notice of Claim

Written notice must be sent to The Principal by or for a Member or Dependent who wishes to file claim for benefits under this Group Policy. This notice must be sent within 20 calendar days after the date of loss. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

### Article 2 - Claim Forms

The Principal, when it receives notice of claim, will provide appropriate claim forms for filing proof of loss. If the forms are not provided within 15 calendar days after The Principal receives notice of claim, the person will be considered to have complied with the requirements of the Group Policy regarding proof of loss upon submitting, within the time specified below for filing proof of loss, Written proof covering the occurrence, character, and extent of the loss.

### Article 3 - Proof of Loss

Written proof of loss must be sent to The Principal within 12 months after the date of the loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when The Principal receives proof of loss. Proof of loss includes the patient's name, Member's name (if different from the patient's name), provider of services, dates of service, diagnosis, description of Treatment or Service provided and the extent of the loss. The Principal may request additional information to substantiate loss or require a Signed unaltered authorization to obtain that information from the provider. Failure to comply with The Principal's request could result in declination of the claim. The Principal may also require x-rays, dental charts, and other evidence needed to determine the dental condition treated and the services provided.

### Article 4 - Payment, Denial, and Review

The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, The Principal will send a Written explanation prior to the expiration of the 30 calendar days. If The Principal does not deny the claim and requests additional information to complete the review, the claimant is then allowed up to 45 calendar days to provide all additional information requested. The Principal will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no

additional information is received.

In actual practice, benefits under this Group Policy may be payable sooner, provided The Principal receives complete and proper proof of loss. If a claim is not payable or cannot be processed, The Principal will submit a detailed explanation of the basis for its denial.

A claimant may request an appeal of a claim denial by Written request to The Principal within 180 calendar days of receipt of the notice of denial. The Principal will make a full and fair review of the claim. The Principal may require additional information to make the review. The Principal will notify the claimant in Writing of the appeal decision within 60 calendar days of receiving the appeal request. The appeal review must be completed before filing a civil action or pursuing any other legal remedies.

For purposes of this section, "claimant" means Member or Dependent.

**Article 5 - Dental Treatment Plan**

The Principal encourages the use of predeterminations to determine the extent of coverage for a proposed course of treatment. A Dental Treatment Plan may be filed with The Principal before treatment begins. Upon receipt, The Principal will provide a Written response indicating the benefits that may be payable for the proposed treatment. The Principal suggests predetermination of benefits for the following non-emergency types of treatments: inlays, onlays, single crowns, prosthetics, periodontics and oral surgery.

The filing of a Dental Treatment Plan is intended to help avoid any misunderstanding between the Dentist, the insured, and The Principal as to how much will be paid for dental work. A Dental Treatment Plan is not a guarantee of what The Principal will pay. It informs the insured person and the Dentist, in advance, what The Principal will pay for a covered dental service named in the Dental Treatment Plan. If The Principal does not agree with a Dental Treatment Plan, The Principal has the right to base payments on treatment suited to the covered person's condition by accepted standards of dental practice.

**Article 6 - Facility of Payment**

Benefits under this Group Policy will be payable immediately after The Principal receives complete and proper proof of loss.

The Principal will normally pay all benefits to the Member. However, if the claimed benefits are for dental care provided for a Dependent, The Principal may make payment to the Dependent. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge The Principal to the full extent of those payments.

a. If payment amounts remain due upon a Member's death, those amounts may, at The

Principal's option, be paid to the Member's estate, spouse, child, parent, or provider of dental services.

b. If The Principal believes a person is not legally able to give a valid receipt for a benefit payment and no guardian has been appointed, The Principal may pay whoever has assumed the care and support of the person.

c. Benefits payable to a PPO Provider will be paid directly to the PPO Provider on behalf of the Member or Dependent.

**Note:** When benefits under this Group Policy are payable for Treatment or Services received from a foreign provider, the claim must be filed in English and requested in American currency amounts. Such claims will be payable for Covered Charges for Treatment or Services but only to the extent that the actual cost charged does not exceed Prevailing Charges. Benefits will be paid directly to the Member. No assignments will be made to foreign providers.

**Article 7 - Recoding of Procedures**

When a claim contains one or more procedure codes with the same date of service, The Principal may review the claim to determine whether it contains, among other things, coding irregularities (including duplicative or combined codes), coding conflicts or coding errors. The Principal will base such review on generally recognized and authoritative coding resources, including but not limited to: Current Dental Terminology (CDT).

If The Principal determines, in its own discretion, that the claim may be more appropriately coded using the same or different codes, the claim will be recoded and processed accordingly to determine the allowable amount and extent of benefits.

**Article 8 - Dental Examinations**

The Principal may have the person whose loss is the basis for claim examined by a Dentist. The Principal will pay for these examinations and will choose the Dentist to perform them.

**Article 9 - Legal Action**

Legal action to recover benefits under this Group Policy may not be started earlier than 60 calendar days after required proof of loss has been filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after that proof is required to be filed.

**This policy has been updated effective January 1, 2013**

**Article 10 - Time Limits**

Any time limit listed in this section will be adjusted as required by law.

**This policy has been updated effective January 1, 2013**

## Section C (1) - Replacement of a Prior Plan

### Article 1 - Applicability

When insurance under this Group Policy replaces coverage under a Prior Plan, this section will apply to those Members and Dependents who:

a. are eligible and enrolled under this Group Policy on its Date of Issue; and

b. were covered under the Prior Plan on the date of its termination.

### Article 2 - Benefits Payable

Benefits may be payable under this section when benefits under this Group Policy would otherwise be denied solely because of the Actively at Work provision, provided that:

a. benefits would have been paid under the Prior Plan had it remained in force; and

b. benefits are not paid under the Prior Plan due to its termination.

For Members who are not Actively at Work on the Date of Issue of this Group Policy and have not been Actively at Work since then, the benefits payable, if any, under this section will be the lesser of:

a. the benefits of this Group Policy; or

b. the benefits that would have been paid by the Prior Plan had it remained in force.

For Members who are Actively at Work on the Date of Issue of this Group Policy, the benefits payable under this section will be the benefits of this Group Policy.

In no event will benefits be paid for any Treatment or Service:

a. received before the Date of Issue of this Group Policy; or

b. for which benefits are paid under the Prior Plan; or

c. for which benefits would have been paid under the Prior Plan (including that plan's extended benefit provision) in the absence of this section.

**This policy has been updated effective January 1, 2013**

## Section D - Coordination with Other Benefits

### Article 1 - Purpose

The intent of this section is to provide that the sum of benefits paid under this Group Policy plus benefits paid under all other Plans will not exceed the lesser of the financial liability of the Member or Dependent or the Prevailing Charge of The Principal for a Treatment or Service.

### Article 2 - Definitions

As used in this section, the terms listed below will mean:

**a. Plan**

Any dental expense benefits provided under:

(1) any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or association; and
(2) any program required or established by state or Federal law (including Medicare Parts A and B); and
(3) any program sponsored by or arranged through a school or other educational agency; and
(4) the first-party medical expense provisions of any automobile policy issued under a no-fault insurance statute and traditional fault-type contracts.

The term Plan will not include benefits provided under a student accident policy, nor will the term Plan include benefits provided under a state medical assistance program where eligibility is based on financial need.

Also, the term Plan will apply separately to those parts of any program that contain provisions for coordination of benefits with other Plans and separately to those parts of any program which do not contain such provisions.

**b. Primary Plan/Secondary Plan**

The order of benefit determination rules determine whether This Plan is a "Primary Plan" or a "Secondary Plan" when compared to another Plan covering the person.

When this Plan is Primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is Secondary, its benefits are determined after those of another Plan and may be reduced because of the

**This policy has been updated effective January 1, 2013**

Primary Plan's benefits.

**c. Allowable Expense**

A dental care service or expense, including Deductibles, coinsurance, and Copayments, if any, that is covered at least in part by any of the Plans covering the person for whom benefits are claimed. When a Plan provides benefits in the form of services (for example a DHMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

(1) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.
(2) The amount a benefit is reduced by the Primary Plan because a covered person does not comply with the Plan provisions. Example of this provision is preferred provider arrangements.

**d. Claim Determination Period**

The part of a Calendar Year during which a Member or Dependent would receive benefit payments under this Group Policy if this section were not in force.

**Article 3 - Effect on Benefits**

Benefits otherwise payable under this Group Policy for Allowable Expenses during a Claim Determination Period may be reduced if:

a. benefits are payable under any other Plan for the same Allowable Expenses; and

b. the rules listed in Article 4 below provide that benefits payable under the other Plan are to be determined before the benefits payable under this Group Policy.

The reduction will be the amount needed to provide that the sum of payments under this Group Policy plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses. Each benefit that would be payable in the absence of this section will be reduced proportionately. Any such reduced amount will be charged against any applicable benefit limit of this Plan.

For this purpose, benefits payable under other Plans will include the benefits that would have been paid had claim been made for them. Also, for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B whether or not the person is covered under that Part B.

**This policy has been updated effective January 1, 2013**

**Article 4 - Order of Benefit Determination**

Except as described in Article 5 below, the benefits payable of a Plan that does not have a coordination of benefits provision substantially similar to the provision described in this section will be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination will be:

a. Nondependent/Dependent. The benefits of a Plan which covers the person for whom benefits are claimed as an employee, Member, or subscriber (that is, other than as a Dependent) are determined before the benefits of a Plan which covers the person as a Dependent. Exception: If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(1) secondary to the Plan covering the person as a Dependent; and
(2) primary to the Plan covering the person as other than a Dependent (e.g., a retired employee);

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.

b. Dependent Child--Parents Not Separated or Divorced. Except as stated in paragraph c. below, when this Group Policy and another Plan cover the same child as a Dependent of different persons called "parents," the benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that year; but 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 another Plan does not have the rule described above, but instead has a rule based on 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 Parents. If two or more Plans cover a Dependent Child of divorced or separated parents, benefits for the Dependent Child are determined in this order:

(1) first, the Plan of the parent with custody of the Dependent Child;
(2) then, the Plan of the spouse of the parent with custody of the Dependent Child; and
(3) finally, the Plan of the parent not having custody of the Dependent 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 Dependent 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.

d. Active/Inactive Employee. The benefits of a Plan which covers the person for whom benefits are claimed as an employee who is neither laid off nor retired, or as that employee's Dependent, are determined before the benefits 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 will not apply.

e. Continuation of Coverage. If a person for whom coverage is provided under a right of continuation according to Federal or state law is also covered under another Plan, the following will be the order of benefit determination:

(1) first, the benefits of a Plan covering the person as an employee, Member or subscriber (or as that person's Dependent);
(2) second, the benefits under the continuation coverage.

If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

f. Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the benefits of the Plan which covered the person for whom benefits are claimed longer are determined before those of the Plan which covered that person for the shorter time.

**Article 5 - Medicare Exception**

Unless otherwise required by Federal law, benefits payable under Medicare will be determined before the benefits payable under this Group Policy.

**Article 6 - Exchange of Information**

Any person who claims benefits under this Group Policy must, upon request, provide all information The Principal believes is needed to coordinate benefits as described in this section.

In addition, all information The Principal believes is needed to coordinate benefits may be exchanged with other companies, organizations, or persons.

**Article 7 - Facility of Payment**

**This policy has been updated effective January 1, 2013**

The Principal may reimburse any other Plan if:

a. benefits were paid by that other Plan; but

b. should have been paid under this Group Policy in accordance with this section.

In such instances, the reimbursement amounts will be considered benefits paid under this Group Policy and, to the extent of those amounts, will discharge The Principal from liability.

**Article 8 - Right of Recovery**

If, in accordance with this section, it is determined that benefits paid under this Group Policy should have been paid by any other Plan, The Principal will have the right to recover those payments from:

a. the person to or for whom the benefits were paid; and/or

b. the other companies or organizations liable for the benefit payments.

## Section E - Complaint and Grievance Procedures

### Article 1 - Applicability

A Member or Dependent or a designated representative or provider acting on behalf of the Member or Dependent may file a Grievance if they are dissatisfied with any action The Principal may have taken. A letter can be sent to the local service center (the address is shown on the Member's ID card). The right to a Grievance does not apply to the providers' complaints concerning claim payment, handling, or reimbursement for dental care services.

As used in this Group Policy, "Grievance" means a complaint submitted by a Member or Dependent or a designated representative or provider acting on behalf of the Member or Dependent about any of the following:

a. the availability, delivery, or quality of dental care services, including a complaint regarding an adverse determination made pursuant to this PART IV, Section F; or

b. benefits or claim payment, handling, or reimbursement for dental care services; or

c. matters pertaining to the contractual relationship between a Member or Dependent and The Principal.

### Article 2 - Grievance Review

Upon receipt of a Grievance, The Principal will provide the claimant with the name, address, and telephone number of a person designated to coordinate the Grievance review. Written notification of the determination will be provided to the Member or Dependent and the patient's Dentist, if applicable.

**This policy has been updated effective January 1, 2013**

## Section F - External Review

### Article 1 - Right to Request an External Review of an Adverse Determination

A Member or Dependent or a designated representative or provider acting on behalf of the Member or Dependent has the right to apply to the Insurance Commissioner for an External Review of an Adverse Determination.

The external review request must be in Writing and be filed within 60 days of the receipt of the Adverse Determination.

The Insurance Commissioner's address and telephone number is:

Consumer Services/Benefit Inquiry Section
Michigan Division of Insurance
P.O. Box 30220
Lansing, MI 48909-7720
1-877-999-6442

The Member or Dependent must exhaust the complaint and grievance process as described in this PART IV, Section E before requesting an external review.

When filing a request for an external review, the Member or Dependent will be required to authorize the release of any dental records that may be required to be reviewed for the purpose of reaching a decision on the external review.

"Adverse Determination" means a determination by The Principal that availability of care or other dental care service has been reviewed and based upon the information provided, does not meet the requirement for dental necessity, appropriateness, dental care setting, level of care and effectiveness, and the requested service is therefore denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an Adverse Determination.

**This policy has been updated effective January 1, 2013**

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**Principal Life Insurance Company**
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