

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
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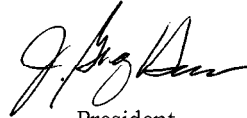
CERTIFICATE GROUP DENTAL INSURANCE

Policyholder:	Toppenish School District
Policy Number:	519224-A
Effective Date:	October 1, 1999

A Group Policy has been issued to the Policyholder. We certify that you will be insured as provided by the terms of the Group Policy. If your coverage is changed by an amendment to the Group Policy, we will provide the Policyholder with a revised Certificate or other notice to be given to you.

Possession of this Certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate.

"We", "us" and "our" mean Standard Insurance Company. "You" and "your", as indicated by their usage, mean the Member, the Dependents, or both. All other defined terms appear with the initial letter capitalized. Section headings, and references to them, appear in boldface type.



President

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COVERAGE FEATURES

This section contains many of the features of your dental insurance. Other provisions, including exclusions and limitations, appear in other sections. Please refer to the text of each section for full details. The Table of Contents and the Index of Defined Terms help locate sections and definitions.

GENERAL POLICY INFORMATION

Group Policy Number:	519225-A
Policyholder:	Toppenish School District
Employer(s):	Toppenish School District
Group Policy Effective Date:	October 1, 1999
Policy Issued in:	Washington

BECOMING INSURED AS A MEMBER

To become insured you must: (a) Be a Member; (b) Complete your Eligibility Waiting Period; and (c) Meet the requirements in **When Insurance Becomes Effective**. Other information is found in **Reinstatement**.

Definition of Member:	You are a Member if you are: <ol style="list-style-type: none">1. An active TEA or administrative employee of the Employer, covered under the Employer-sponsored medical plan;2. Regularly working at least 10 days per month; and3. A citizen or resident of the United States or Canada.
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You are not a Member if you are:

1. A temporary or seasonal employee; or
2. A full time member of the armed forces of any country.

Class Definition:	None
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Eligibility Waiting Period:	If you become a Member on or before the 15 th day of the calendar month, you are eligible on the first day of the calendar month following the date you become a Member.
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If you become a Member after the 15th day of the calendar month, you are eligible on the first day of the calendar month following 30 consecutive days as a Member.

Annual Open Enrollment Period:	The period from September 1 through September 30 each year.
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PREMIUM CONTRIBUTIONS BY MEMBERS

Members:	Noncontributory
Dependents:	Contributory

OTHER PROVISIONS

Preferred Provider Organization:	Ameritas
Dependents Coverage:	Yes
Coverage for Dependents covered under another group dental plan:	Yes
COBRA Continuation:	Yes. The COBRA continuation rate is a percentage of the contribution rate currently in effect on each due date. The contribution rate may change after you cease to be Actively At Work. The percentage is as follows: 18 Month Continuation - 102% 29 Month Continuation - 102% during the first 18 months, 150% during the next 11 months 36 month Continuation - 102%
Orthodontic Dental Benefits:	Yes, for all Insured Persons.
TMJ Disorder Dental Benefits:	Yes
Benefit Extension Period under Prior Plan:	The first 30 days following the effective date of your Insurance.
Prosthetics Limitation Period:	36 months, if your Insurance becomes effective on the Group Policy Effective Date. However, the Prosthetics Limitation will be reduced by any period during which you were continuously covered under the Employer's group dental insurance plan immediately preceding the Group Policy Effective Date. 36 months, if your Insurance becomes effective after the Group Policy Effective Date.
Strike Continuation:	Yes. The Strike Continuation premium percentage is 100% of the Premium Rate.

BENEFIT WAITING PERIOD

Major Dental Expenses:	None
Orthodontic Dental Expenses:	None
TMJ Disorder Dental Expenses:	None

See **Dental Benefit**, D. Benefit Waiting Period for more information.

SCHEDULE OF DENTAL BENEFITS

Dental Expenses	Dental Benefit Percentage
PPO Dental Professional	
Preventive Dental Expenses:	70%
Basic Dental Expenses:	70%
Major Dental Expenses:	50%
Orthodontic Dental Expenses:	50%
TMJ Disorder Dental Expenses:	50%
Non-PPO Dental Professional	
Preventive Dental Expenses:	70%
Basic Dental Expenses:	70%
Major Dental Expenses:	50%
Orthodontic Dental Expenses:	50%
TMJ Disorder Dental Expenses:	50%

Incentive Provision

The Dental Benefit Percentage for Preventive Dental Expenses and Basic Dental Expenses will be increased 10% each Benefit Year if you received dental services during the preceding Benefit Year.

The Dental Benefit Percentage for Preventive Dental Expenses and Basic Dental Expenses will be decreased 10% each Benefit Year if you did not receive dental services during the preceding Benefit Year.

The Dental Benefit Percentage for Preventive Dental Expenses and Basic Dental Expenses will never be greater than 100% or less than 70%. Members who are insured on September 30, 2003 will remain at or move up to the 100% incentive level.

If you transfer from another school district and were insured under a WEA incentive plan, your claim history, incentive level, maximum and deductible information for you and your dependents will continue and be credited.

Each insured Person establishes their own incentive level.

Deductible Amount:

The Deductible Amount for each Insured Person for all expenses other than Preventive, Orthodontic, or TMJ Disorder Dental Expenses is: \$25

The Deductible Amount is satisfied for a family of 3 or more Insured Persons when Incurred Basic and Major Dental Expenses equal 3 times the Deductible Amount. Only the Deductible Amount of each Insured Person's Basic and Major Dental Expenses is applied to satisfy the family Deductible Amount.

Dental Expenses Incurred under the Prior Plan will count toward the Deductible Amount for the first Benefit Year under the Group Policy if Incurred during that Benefit Year.

There is no Deductible Amount for Preventive, Orthodontic, or TMJ Disorder Dental Expenses.

Maximum Amounts:

All Dental Benefits other than Orthodontic or TMJ Disorder Dental Benefits:	\$1,500 per Benefit Year for each Insured Person
Orthodontic Dental Benefits:	\$1,000 lifetime maximum for each insured Person
TMJ Disorder Dental Benefit:	\$1,000 per Benefit Year for each insured Person \$5,000 lifetime maximum for each Insured Person

The **Coordination Of Benefits** section applies if an Insured Person has dental coverage under more than one Plan.

Benefit Year: The period from January 1, 1999 to the following January 1 and each successive 12 month period while the Group Policy remains in effect.

Policy Year: The period from October 1, 1999 to October 1, 2000 and each successive 12 month period while the Group Policy remains in effect.

INTRODUCTION

A. Insuring Clause

We will pay Dental Benefits according to the terms of the Group Policy for Dental Expenses Incurred by you while you are insured under the Group Policy, after we receive satisfactory Proof Of Loss satisfactory to us.

Takeover Provision: A Dental Benefit will be paid for the following Dental Expenses Incurred before the Effective Date of your Insurance if: (a) you were insured under the Prior Plan on the day before the Effective Date of your Insurance; (b) dental benefits would have been paid under the Prior Plan if it had remained in force; and (c) the dental service or supply is provided after the end of the Benefit Extension Period period under the Prior Plan as shown in the **Coverage Features**:

1. Bridgework, crown or onlay.
2. Placement or modification of a full or partial denture.
3. Root canal therapy.

B. Free Choice Of Dental Professional

You may select a Dental Professional of your choice. You may choose either a PPO Dental Professional or a Non-PPO Dental Professional. However, the benefit and terms of your coverage may differ according to your choice.

The Dental Professional you select is responsible for the quality of dental care you receive. We are not responsible for any injuries you may suffer while receiving dental care.

C. Predetermination Of Dental Benefit

If your Dental Professional gives us a Treatment Plan, we will tell you and your Dental Professional the amount of Dental Benefit we will pay. We recommend your Dental Professional give us a Treatment Plan when dental services and supplies may result in Dental Expenses of \$250 or more.

Treatment Plan means the Dental Professional's report which lists the dental services and supplies recommended and the charge for each item. We may request additional information.

DENTAL BENEFIT

A. Dental Benefit

The Dental Benefit is a percentage of the Reasonable and Customary Charge for those dental services and supplies which are listed in **Dental Expenses**. The percentage that applies is stated in the **Coverage Features**.

B. Deductible Amount

Deductible Amount means the amount of (a) the Reasonable and Customary Charge with respect to a Non-PPO Dental Professional, or (b) the Negotiated Fee Schedule with respect to a PPO Dental Professional, for Dental Expenses you must incur during the Benefit Year before we will pay a Dental Benefit.

The Deductible Amount is stated in the **Coverage Features**.

C. Maximum Amount of Dental Benefit

The Dental Benefit we will pay is subject to a Maximum Amount. The Maximum Amounts are stated in the **Coverage Features**.

D. Benefit Waiting Period

The **Coverage Features** states the length of the Benefit Waiting Period and which Dental Expenses are subject to a Benefit Waiting Period.

Your Insurance must be in effect continuously for the length of the Benefit Waiting Period stated in the **Coverage Features** before Dental Expenses subject to the Benefit Waiting Period will be covered. Dental Expenses subject to a Benefit Waiting Period will not be applied toward Deductible Amount if Incurred during the Benefit Waiting Period.

DENTAL EXPENSES

Dental Expenses means the charges for the dental services and supplies provided by your Dental Professional and listed below.

A. Preventive Dental Expenses

Preventive Dental Expenses means charges for the following services and supplies:

1. Prophylaxis, but only once in any 5-month period.
2. Oral Evaluations of the mouth and teeth, but only once in any 5-month period.
3. Fluoride treatments for a Child under age 20, but only once in any 5-month period.
4. The following Dental X-rays:
 - a. One set of full mouth or panoramic X-rays in any 3-year period.
 - b. One set of bitewing X-rays in any 5-month period.
 - c. Periapical X-rays.
 - d. One set of occlusal X-rays in any 2-year period.
5. Bacteriologic cultures and examination of oral tissue excised for biopsy.
6. Emergency palliative treatment or evaluation, but only twice in any 12 month period.
7. Space maintainers designed to preserve the space between teeth caused by the premature loss of a primary tooth. Orthodontic space maintainers are not included.
8. Application of sealants for a Child under age 17, but only once in any 3-year period and for posterior teeth only.

B. Basic Dental Expenses

Basic Dental Expenses means charges for the following services and supplies:

1. Endodontic treatment, including pulpotomy, apicoectomy, retrograde filling, and root canal therapy.

Charges for root canal therapy for which the pulp chamber was opened before the effective date of your Insurance will not be covered during the Benefit Extension Period shown in the **Coverage Features**, if you were insured under the Prior Plan on the day before the effective date of your Insurance.

2. Simple, non-surgical extraction of one or more teeth.
3. Oral surgery and postoperative treatment as follows:
 - a. Surgical extraction of one or more teeth.
 - b. Extraction of the tooth root.

- c. Alveolectomy, alveoplasty and frenectomy.
 - d. Excision of hyperplastic tissue or oral tissue for biopsy or exostosis.
 - e. Reimplantation or transplant of a natural tooth.
 - f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst.
 - g. General anesthetics, analgesics, and intravenous sedation when given as part of an oral surgery listed in this subsection.
4. Periodontal services as follows:
 - a. Periodontal maintenance therapy, but only once in any 2 1/2-month period.
 - b. Root scaling and root planing, but only once per quadrant of the mouth in any 5-month period.
 - c. Occlusal adjustment, but only if performed in conjunction with covered periodontal surgery.
 - d. Full mouth debridement, but only once in any 3 year period.
 - e. Gingivectomy, gingival curettage, and mucogingival surgery (other than crown lengthening).
 - f. Osseous surgery including flap entry and closure.
 - g. Pedicle or free soft tissue grafts.
 - h. Bone grafts, either single or multiple.
 - i. Provisional splinting, either intracoronal or extracoronal.
 - j. Excision of pericoronal gingiva.
 5. Study models, but only once in any 3-year period.
 6. Crown build-up.
 7. Stainless steel crowns.
 8. Pin retention of fillings.
 9. Fillings using amalgam, silicate, acrylic, synthetic porcelain, and resins or composite filling material to restore teeth broken down by decay or injury.

Fillings performed on posterior teeth using resins or composite filling material will be paid as fillings using amalgam.

Fillings performed on the following surfaces of anterior teeth will be paid as single-surface fillings: Mesiolingual; distolingual; mesiobuccal; and distobuccal.
 10. Recementing inlays, onlays and crowns.
 11. Recementing bridges.
 12. Repairs to full and partial dentures and bridges, but only once in any 2-year period. No Dental Benefit will be paid for repair costs that exceed 20% of the replacement cost.
 13. Antibiotic injections given by the treating Dental Professional.
 14. Dental consultations, but not more than twice in any 12-month period.

15. Restorative services and supplies as follows:

Gold or porcelain inlays, onlays, veneers and crowns but only when the tooth, because of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling material.

Charges for the above restorative services, for a tooth which was prepared before the effective date of your Insurance, will not be covered during the Benefit Extension Period shown in the **Coverage Features**, if you were insured under the Prior Plan on the day before the effective date of your Insurance.

16. Replacement of permanent devices, as follows:

Replacement of an existing inlay, onlay, veneer or permanent crown but only if it has been at least 5 years since the restoration was initially placed or last replaced.

17. Replacement of temporary crowns, as follows:

Replacement of a temporary crown, but only if the temporary crown has been in place for less than 12 months. However, the Dental Benefit payable for the permanent crown will be reduced by any Dental Benefit we paid for placement or replacement of the temporary crown.

A temporary crown that has been in place for more than 12 months will be considered a permanent crown for purposes of replacement.

C. Major Dental Expenses

Major Dental Expenses means charges for the following services and supplies:

1. Occlusal guards (night guards) for treatment of bruxism, but only once in any 5 year period.
2. Restorative services and supplies for post and core on non-vital teeth.
3. Prosthetic services and supplies as follows:
 - a. Initial placement of fixed bridgework (including acid-etch metal bridges), full or partial dentures, or the addition of a tooth to existing partial dentures, but only if the placement or addition includes replacement of a natural tooth lost or extracted.
 - i. While you are insured under the Group Policy.
 - ii. While you were insured under the Prior Plan and that insurance continued in effect until the day before the effective date of your Insurance.

This limitation will not apply after your Insurance has been continuously in effect for the length of the Prosthetics Limitation Period shown in the **Coverage Features**. This limitation will not apply to a Child adopted while the Member is insured under the Group Policy.

Charges for the above prosthetic services for a tooth which was prepared before the effective date of your Insurance will not be covered during the Benefit Extension Period shown in the **Coverage Features**, if you were insured under the Prior Plan.

- b. Relining or rebasing of existing removable full or partial dentures, but only if it has been at least one year since the denture was placed. Charges for these services are covered only once in any 2-year period.
4. Replacement of permanent devices as follows:

Replacement of full or partial dentures or fixed bridgework which cannot be made serviceable, but only if it has been at least 5 years since the denture or bridgework was initially placed or last replaced. However, this limitation will not apply if replacement is made necessary by the loss or extraction of one or more natural teeth.

- i. While your Insurance is in effect; or
- ii. While you were insured under the Prior Plan and that insurance is continuously in effect until you become insured under the Group Policy.

No Dental Benefit will be paid for any duplicate prosthetic appliance or the replacement of any lost, missing, or stolen prosthetic appliance.

5. Replacement of Temporary Devices, as follows:

Replacement of an interim prosthetic device, temporary denture, temporary stayplate or a flipper with a permanent device is covered, but only if the temporary device has been in place for less than 12 months. However, the Dental Benefit payable for the permanent device will be reduced by any Dental Benefit we paid for placement or replacement of the Temporary Device.

A temporary device that has been in place for more than 12 months will be considered a permanent device for purposes of replacement.

D. Orthodontic Dental Expenses

The **Coverage Features** states who is covered for Orthodontic Dental Expenses and whether a Benefit Waiting Period applies.

Orthodontic Dental Expenses means charges for the following services and supplies:

1. Cephalometric film.
2. Removable, fixed or cemented appliance for tooth guidance or for interceptive orthodontic treatment, including impressions, installation and all adjustments within 6 months of installation.
3. Comprehensive (full-banded) orthodontic treatment of transitional or permanent teeth.

No Dental Benefit will be paid for Orthodontic Dental Expenses incurred after the date Insurance ends.

Takeover Provision: If the first active orthodontic appliance was placed before the effective date of your Insurance, Dental Benefits will be paid for Orthodontic Dental Expenses if:

- a. You were insured under the Prior Plan on the day before the effective date of your Insurance;
- b. You Incur Orthodontic Dental Expenses after that date;
- c. You are continuously insured under the Group Policy from the effective date of your Insurance through the date Orthodontic Dental Expenses are Incurred; and
- d. Orthodontic dental benefits would have been payable under the Prior Plan, if it had remained in force.

However, the lifetime Maximum Amount for Orthodontic Dental Benefits under the Group Policy will be reduced by all payments for orthodontic treatment made under the Employer's group dental benefit program.

E. TMJ Disorder Dental Expenses

TMJ Disorder Dental Expenses means charges for services and supplies provided by a Dental Professional listed below and in Parts A, B, C and D of **Dental Expenses** above that are related to diagnosis and treatment of a temporomandibular joint disorder:

1. Temporomandibular joint films, not including posterior-anterior or lateral skull and facial bone survey films.
2. Temporomandibular joint arthrogram, including injection.

3. Treatment of the atypical or extended skeletal case.
4. Removable, fixed, or cemented appliance for minor treatment for tooth guidance or to control harmful habits, including impressions, installation, and all adjustments within 6 months of installation.
5. Treatment of temporomandibular joint musculature pain, internal derangement, arthritis, abnormal range of motion or limitation of motion.
6. Treatment of difficulty in speaking, or chewing or swallowing food.
7. Treatment of infection or disease.

Dental Benefits for TMJ Disorder Dental Expenses are paid as the charges are incurred.

No Dental Benefits will be paid for charges incurred after the date your Insurance ends even if the TMJ disorder dental treatment begins while you are insured under the Group Policy.

Charges for procedures related to diagnosis and treatment of a TMJ disorder which began before the effective date of your Insurance under the Group Policy are not covered, except as provided in the following takeover provision.

TAKEOVER PROVISION: If treatment of a TMJ disorder began before the effective date of the Group Policy, we will pay Dental Benefits for ongoing TMJ Disorder Dental Expenses incurred after the effective date of the Group Policy provided that dental benefits for your TMJ disorder treatment were payable under the Prior Plan.

The lifetime Maximum Amount payable under the Group Policy for TMJ Disorder Dental Expenses is the lesser of A and B, reduced by C:

- A = The lifetime maximum amount payable for TMJ disorder dental expenses under the Prior Plan.
- B = The lifetime Maximum Amount of TMJ Disorder Dental Expenses payable under the Group Policy.
- C = The amount of all payments made for treatment of the TMJ disorder under the Prior Plan.

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EXCLUSIONS

No Dental Benefit will be paid for the following charges:

1. Charges for services or supplies other than the Dental Expenses listed in the Group Policy.
2. Charges for office visits.
3. Charges which exceed the Reasonable and Customary Charge for the services or supplies provided.
4. Charges which exceed the Reasonable and Customary Charge for the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.
5. Charges which exceed the Reasonable And Customary Charge that would have been charged had all required dental services and supplies been provided by the same Dental Professional, if you (a) change Dental Professionals while receiving treatment; or (b) receive care from more than one Dental Professional for one dental procedure.
6. Charges for services or supplies for which no charge would be made in the absence of insurance or for which you are not obligated to pay.

7. Charges for services or supplies which do not have a reasonably favorable prognosis or which are not necessary according to generally accepted standards of dental practice.
8. Charges for services or supplies that are not generally accepted by the dental profession or are experimental or investigational.
9. Charges for services or supplies that are primarily for cosmetic purposes.
10. Charges for Periodontal Splints, except provisional splinting covered under the Group Policy.
11. Charges for appliances or restorations to increase vertical dimension, to restore an occlusion, or for gnathologic recordings.
12. Charges for services or supplies related to diagnosis or treatment of temporomandibular joint disorder or craniomandibular disorder.
13. Charges for: implants; precision attachments or semi-precision attachments; acid etch (other than acid etch metal bridge retainers); drugs; bite regulation; bite analysis; treatment of fractures; orthognathic surgery; instruction in dental plaque control or dental hygienics; or nutritional counseling.
14. Charges for services or supplies for which you are entitled to benefits under any workers' compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an Injury or Sickness arising out of or in the course of any employment for wage or profit.
15. Charges for Dental Expenses for which benefits are payable under any medical expense plan or under any liability policy including, but not limited to, an automobile policy or a homeowner's policy.
16. Charges for services or supplies received as a result of any dental condition caused or contributed to by War or any act of War. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.
17. Charges for maxillo-facial surgery, myofunctional therapy, cleft palate treatment, or treatment of micrognathia or macrognathia.
18. Charges for lingually placed direct bonded appliances and arch wires.
19. Charges for pulp capping or pulp vitality tests.
20. Charges for Crown lengthening.

COORDINATION OF BENEFITS

This section applies if an Insured Person has dental coverage under more than one Plan. All Dental Benefits are subject to this section.

A. Definitions For This Section

1. Plan means the Group Policy and any of the following dental plans providing benefits for dental services or supplies:
 - a. Any group or blanket insurance policy.
 - b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.
 - c. Any labor/management trustee plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

- d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does not include a state plan under Medicaid (Title XVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.
- e. Any other group-type coverage which is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.

Each contract or other arrangement for coverage under a through e above is a separate Plan. Also, if an arrangement has two parts and the coordination of benefits rules apply only to one of the two, each of the parts is a separate Plan.

2. Plan does not include the following:

- a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual Health Maintenance Organizations or other prepayment service, group practice plans.
- b. Coverages covering grammar school, high school and college students for accidents only, including athletic injuries.

3. Allowable Expense means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering you. When a Plan provides services rather than cash benefits, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had claim been made for them.

4. Claim Determination Period means a Policy Year, but does not include any time when you were not insured under the Group Policy.

B. Order Of Benefits: Which Plan Pays First

If payment under the Group Policy must be made first, that payment will not be reduced because of this section.

If a Plan does not have a coordination of benefits provision, that Plan must provide benefits first.

If a Plan also has a coordination of benefits provision, 1 through 5 below will apply.

1. The benefits of a Plan which covers a person as an employee, member or subscriber are determined before those of a Plan which covers the person as a dependent.
2. If a Dependent Child is covered by different parents under separate Plans, the benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined first. If both parents have the same birthday, the benefits of the Plan which covered a parent longer are determined first.

If the other Plan has the gender rule, the other Plan will determine the order of benefits.

3. If a Dependent Child is covered by divorced or separated parents under two or more Plans, benefits for that Child will be determined in the following order:
 - a. The Plan of the parent with custody.
 - b. The Plan of the spouse of the parent with custody.
 - c. The Plan of the parent not having custody.

However, if the specific terms of a court decree establish a parent's responsibility to provide coverage, 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 during which benefits are paid or provided before the entity has that actual knowledge.

4. The benefits of a Plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, this rule will be ignored.
5. If the rules above do not establish the order of benefits, the benefits of a Plan that has covered a person for a longer period will be determined first.

C. Effect On Benefits When Other Plan Pays First

If all or any part of a Dental Expense for which you claim Dental Benefits is an Allowable Expense under any other Plan, then Dental Benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the Allowable Expense.

However, the amount by which Dental Benefits have been reduced during the Claim Determination Period will be used by us to pay Allowable Expenses not otherwise paid which were Incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims that have been submitted in the current Claim Determination Period.

If Dental Benefits are reduced as described above, each benefit will be reduced proportionately. The total amount paid will be charged toward the Maximum Amounts.

If you have dental coverage under another Plan, we encourage you to submit your claim to us and the other Plan at the same time so that the proper coordinated benefits may be most quickly determined and paid.

D. Right To Receive And Release Information

We may with your consent:

1. Release any information with respect to your coverage and benefits under the Group Policy; and
2. Obtain from any other insurance company, organization, or person any information with respect to your coverage and benefits under another Plan.

You must provide us with any information necessary to coordinate benefits.

E. Facility Of Payment

Whenever payments which should have been made by us according to this section have been made under another Plan, we may pay the other Plan the amount we should have paid you. Any such payment will be a Dental Benefit and we will be fully discharged from liability to the extent of that payment.

WHEN MEMBER'S INSURANCE BECOMES EFFECTIVE

Your Noncontributory Insurance becomes effective on the date you become eligible.

BECOMING INSURED AS A DEPENDENT

A. Definition Of Dependent

Dependent means the Member's Spouse or Child. Dependent does not include a full-time member of the armed forces of any country.

Spouse means

1. A person to whom you are legally married; or
2. Your Domestic Partner. Domestic Partner means an individual with whom you have completed an affidavit of declaration of domestic partnership, submitted that affidavit to the Employer, and filed that affidavit for public record if required by law.

Child means:

1. The Member's child, from live birth to age 26; or
2. The Member's child who meets either of the following requirements:
 - a. The child is Insured under the Group Policy and, on and after the date on which Insurance would otherwise end because of the Child's age, is continuously Disabled.
 - b. The child was insured under the Prior Plan on the day before the effective date of the Member's Employer coverage under the Group Policy and was Disabled on that day, and is continuously Disabled thereafter.

Child includes any of the following, if they otherwise meet the definition of Child:

- i. The Member's adopted child from time of placement, or earlier, if required by your state insurance code;
- ii. The Member's stepchild if living in the Member's home; and
- iii. A child living in the Member's home and for whom the Member is the court appointed legal guardian.

Disabled and Disability for this definition mean that the Member's child is:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and
2. Chiefly dependent upon the Member for support and maintenance, or institutionalized because of mental retardation or physical handicap.

Proof of Disability must be given on our forms within 31 days after a) the date on which Insurance would otherwise end because of the Child's age or b) the effective date of your Employer's coverage under the Group Policy if the child is Disabled on that date. At reasonable intervals thereafter, we may require further proof of Disability and have the Child examined at our expense.

B. Eligibility For Insurance

You are eligible for Insurance if you are a Dependent of an insured Member, unless you are covered under another group dental plan, and the **Coverage Features** states that such Dependents are not eligible.

C. When Insurance for Dependents Becomes Effective

The **Coverage Features** states whether Insurance for Dependents is Contributory or Noncontributory.

1. Noncontributory Insurance

Noncontributory Dependents Insurance becomes effective on the date you become eligible.

2. Contributory Insurance

The Member must apply in writing for Contributory Dependents Insurance and agree to pay premiums. Your Insurance becomes effective on the latest of:

- a. The date you become eligible. However, the Member may apply for your Insurance after the date you become eligible, if on the date you become eligible for Insurance, you are insured under another employer's group dental benefit program, and thereafter, your coverage under that program ends because you are no longer eligible and the Member applies for Insurance for you within 31 days after your coverage under that program ends.
- b. The date you first acquire a Dependent, if you apply for Contributory Dependents Insurance within 31 days of acquiring a Dependent.
- c. The October 1 following the Annual Enrollment Month, if the Member enrolls you during the Annual Enrollment Month. However, if you were previously enrolled for Contributory Dependents Insurance and are no longer covered, the Member may not re-enroll you for coverage until the Annual Enrollment Period following one year after your Insurance ends.

3. Insurance For Newborn And Adopted Children

A newborn Child is automatically insured from the moment of birth. An adopted Child is automatically insured from the time of placement, or earlier if required by your state insurance code. If your Insurance is Contributory, but the Member does not have Insurance for Dependents, the Member must apply for Insurance within 60 days after the date Insurance under this provision is effective. If the Member does not apply, Insurance for the newborn or adopted Child will end automatically after that 60 day period.

WHEN INSURANCE ENDS

Insurance ends automatically on the earliest of:

1. The date the last period ends for which a premium contribution was made for your Insurance.
2. The date the Group Policy terminates.
3. The date the Member's employment terminates.
4. The last day of the calendar month in which you cease to be a Member. However, if you cease to be a Member because you are working less than the required minimum number of hours, your Insurance will be continued with payment of premium during the following periods unless it ends under 1 through 3 above.
 - a. Through the last day of the calendar month for which your Employer pays you the same amount paid to you immediately before you ceased to be a Member.
 - b. From the date you are unable to be Actively At Work because of Sickness, Injury or Pregnancy, until the earlier of: 1) the last day of the calendar month in which your employment is terminated by you or your Employer; and 2) the end of 6 months.
 - c. During a leave of absence if continuation of your Insurance under the Group Policy is required by the federal or state mandated family or medical leave act or law.
 - d. During any other leave of absence approved by your Employer, but not beyond the end of the calendar month following the calendar month in which the leave of absence begins.
5. For Any Dependent:
 - a. The last day of the calendar month in which you cease to be a Dependent.
 - b. The date the Member's Insurance ends, except as otherwise provided.

- c. The date you become covered under any other group dental plan, if the **Coverage Features** states that Dependents covered under another group dental plan are not eligible for Insurance.
- d. For a Child who is Disabled, 90 days after we mail the Member a request for proof of Disability, if proof is not given.
- e. For a Spouse, the date of your divorce or termination of your relationship with your Domestic Partner.

STRIKE CONTINUATION

Insurance may be continued for up to 6 months when you cease to be a Member because you are working less than the minimum number of hours due to a strike, lockout or other general work stoppage caused by a labor dispute. Rules 1 through 4 below will apply.

1. When your compensation is suspended or terminated because of a work stoppage, your Employer will immediately notify you in writing of your rights under this provision. Your Employer will mail the notice to you at your last address on record with the Employer.
2. You must pay the entire premium for your Insurance, including the Employer's share, if any, to your Employer on or before each Premium Due Date.
3. The premiums for your Insurance during the work stoppage will equal a percentage of the premium rate in effect on the date the work stoppage began (see **Coverage Features**). We may change Premium Rates during the work stoppage according to the terms of the Group Policy.
4. Insurance continued under this provision will end on the earliest of:
 - a. Any Premium Due Date if you fail to make the required premium contribution to your Employer on or before that date.
 - b. The date you have been absent from Active Work for 6 months.
 - c. On the date you begin full-time employment with another employer.
 - d. At our option, on any Premium Due Date if less than 75% of the Members eligible to continue Insurance under this provision make the required premium payment to the Employer.

CONTINUED INSURANCE DURING SCHOOL VACATIONS

If you cease to be a Member because of a school break or vacation, Insurance may be continued during that period.

REINSTATEMENT

If your Dependents Insurance ends, your Dependent may become insured again subject to the following:

1. If Dependents Insurance ends because the Member fails to make a required premium contribution, the Member may not re-enroll the Dependent until the Annual Enrollment Period following one year after the Dependents Insurance ends.
2. If Insurance ends because the Member is on a federal or a state mandated family or medical leave, and the Member becomes eligible for Insurance again immediately following the period allowed, your Insurance will be reinstated pursuant to the federal or state mandated family or medical leave act or law.

EXTENSION OF BENEFITS

We will extend Dental Benefits to cover the following services and supplies the Insured Person receives within 30 days after the date Insurance ends for any reason other than: (a) the Member's failure to make a required premium contribution; or (b) amendment or termination of the Group Policy. This extension will apply only if Dental Benefits would have been paid had Insurance continued.

1. Bridgework, crown, or onlay, if the Incurred Date is before Insurance ends.
2. Placement or modification of a full or partial denture, if the Incurred Date is before Insurance ends.
3. Root canal therapy, if the Incurred Date is before Insurance ends.

CONTINUATION AFTER DEATH OF MEMBER

Insurance for a Dependent will continue without payment of premium for 60 days after the death of the Member.

Insurance will not continue for a Dependent whose Insurance would end for any reason other than the death of the Member.

COBRA CONTINUATION

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after Insurance ends because of a Qualifying Event.

A. Definitions For This Section

Qualified Beneficiary means an Insured Person.

A Qualifying Event occurs when:

1. The Member dies;
2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer;
3. The Member's work hours fall below the minimum number required to be a Member;
4. The Member becomes divorced or legally separated from a Spouse;
5. The Member becomes entitled to receive Medicare benefits under Title XVIII of the Social Security Act;
6. The Child of a Member ceases to be a Dependent; or
7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed.

B. Electing COBRA Continuation

1. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:
 - a. The date on which Insurance would otherwise end; and
 - b. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.

2. Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second 60 day election period if the following requirements are satisfied:
 - a. The Member's Insurance ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;
 - b. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date the Member's Insurance ended due to the trade related termination of their employment; and
 - c. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which the Member was certified eligible for trade adjustment assistance.

C. Notice Requirements

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.
2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:
 - a. The date of the Qualifying Event; or
 - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.
3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:
 - a. The date of the disability determination;
 - b. The date of the Qualifying Event; or
 - c. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.
4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:
 - a. The date of the Qualifying Event; or
 - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.
5. The Employer must give the Plan Administrator written notice within 30 days of Qualifying Event 1, 2, 3, 5, or 7.
6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

In order to protect your rights, Members and Qualified Beneficiaries should inform the Plan Administrator in writing of any change of address.

D. Premium Requirements

Insurance continued under this provision will be retroactive to the date Insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the Premium Due Date thereafter. See **Coverage Features** for the COBRA Continuation Premium Rate.

E. COBRA Continuation Periods

1. 18-Month COBRA Continuation

Each Qualified Beneficiary may continue Insurance for up to 18 months after the date of Qualifying Event 2 or 3 above.

2. 29-Month COBRA Continuation

Each Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, may continue coverage for up to 29 months after the date of the Qualifying Event. All Insured Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

If you are a Dependent, you may continue Coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified Beneficiary who is entitled to continue Insurance for 18 or 29 months may be eligible to continue coverage for up to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

Note: The total period of COBRA continuation available in 1 through 3 above will not exceed 36 months.

4. COBRA Continuation For Certain Bankruptcy Proceedings

If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

F. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;
2. 31 days after the date the last period ends for which a required premium payment was made;
3. The last day of the COBRA continuation period.
4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVIII of the Social Security Act;
5. The first date on which the Qualified Beneficiary is: (a) covered under another group dental policy and (b) not subject to any preexisting condition limitation in that policy.

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CLAIMS

A. Filing A Claim

Claims should be filed on our forms. If we do not provide our forms within 15 days after they are requested, the claim may be submitted in a letter to us. The letter should describe the Dental Expenses for which the claim is made.

B. Time Limits On Filing Proof Of Loss

Proof Of Loss must be provided within 90 days after the Incurred Date of the Dental Expenses. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year

after that 90-day period. If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while you lack legal capacity.

C. Proof Of Loss

Proof Of Loss means written proof that you have Incurred Dental Expenses for which Dental Benefits are payable. Proof Of Loss must be provided at your expense. No Dental Benefit will be paid until Proof Of Loss is satisfied.

D. Documentation Of Proof Of Loss

At your expense, you must submit completed claim statements, your signed authorization for us to obtain information, and any other items we may reasonably require in support of your claim.

E. Investigation Of Claim

We may investigate your claim at any time.

At our expense, we may have a Dental Professional of our choice examine you and review X-rays.

We may deny or suspend payment of Dental Benefits if you or your Dental Professional fails to cooperate with a review or examination by the Dental Professional of our choice.

F. Payment Of Dental Benefits

We will pay all Dental Benefits directly to you immediately after Proof Of Loss is satisfied.

You may authorize us in writing to make payment to the Dental Professional providing the services or supplies.

G. Right To Recover Overpayment

If we make a payment, and you are not entitled to all or a part of that payment, we may recover the payment from you or the Dental Professional. We may deduct the overpayment from future Dental Benefits.

H. Notice Of Decision On Claim

You will receive a written decision on your claim within a reasonable time after we receive your claim.

If you do not receive our decision within 90 days after we receive your claim, you will have an immediate right to request a review as if your claim had been denied.

If we deny any part of your claim, you will receive a written notice of denial containing:

1. The reasons for our decision;
2. Reference to the parts of the Group Policy on which our decision is based;
3. A description of any additional information needed to support your claim; and
4. Information concerning your right to a review of our decision.

I. Review Procedure

If all or part of a claim is denied, you may request a review. You must request a review in writing within 60 days after you receive notice of the denial.

When you request a review, you may send us written comments or other items to support your claim. You may review any non-privileged information that relates to your request for review.

We will review your claim promptly after we receive your request. We will send you a notice of our decision within 60 days after we receive your request, or within 120 days if special circumstances

require an extension. We will state the reasons for our decision and refer you to the relevant parts of the Group Policy.

ALLOCATION OF AUTHORITY

Except for those functions which the Group Policy specifically reserves to the Policyholder, we have full and exclusive authority to control and manage the Group Policy, to administer claims, and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy.

Our authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;
2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it;
3. The right to determine:
 - a. Eligibility for Insurance;
 - b. Entitlement to benefits;
 - c. Amount of benefits payable;
 - d. Sufficiency and the amount of information we may reasonably require to determine a, b, or c above.

Subject to the review procedures of the Group Policy, any decision we make in the exercise of our authority is conclusive and binding.

TIME LIMITS ON LEGAL ACTIONS

No action at law or in equity may be brought until 60 days after you have given us Proof Of Loss. No such action may be brought more than three years after the earlier of:

1. The date we receive Proof Of Loss; and
2. The end of the period within which Proof Of Loss is required to be given.

INCONTESTABILITY PROVISIONS

A. Incontestability Of Insurance

Any statement made to obtain or to increase Insurance is a representation and not a warranty.

No misrepresentation will be used to reduce or deny a claim unless:

1. The Insurance would not have been approved if we had known the truth; and
2. We have given you or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

After Insurance has been in effect for two years during the lifetime of the Insured Person, we will not use a misrepresentation to reduce or deny a claim, unless it was a fraudulent misrepresentation.

B. Incontestability Of Group Policy

Any statement made by the Policyholder or Employer to obtain the Group Policy is a representation and not a warranty.

No misrepresentation by the Policyholder or Employer will be used to deny a claim or to deny the validity of the Group Policy unless:

1. The Group Policy would not have been issued if we had known the truth; and
2. We have given the Policyholder or Employer a copy of a written instrument signed by the Policyholder or Employer which contains the misrepresentation.

The validity of the Group Policy will not be contested after it has been in force for two years, except for nonpayment of premiums or fraudulent misrepresentations.

CLERICAL ERROR AND MISSTATEMENT

A. Clerical Error

Clerical error by the Policyholder or Employer will not:

1. Cause a person to become insured;
2. Invalidate Insurance otherwise validly in force; or
3. Continue Insurance otherwise validly terminated.

B. The Policyholder and your Employer act on their own behalf as your agent, and not as our agent.

C. Misstatement Of Age

If a person's age has been misstated, we will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on:

1. The amount of Insurance based on the correct age; and
2. The difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

TERMINATION OR AMENDMENT OF THE GROUP POLICY

The Group Policy may be terminated by us or the Policyholder according to its terms. It will terminate automatically for nonpayment of premium. The Policyholder may terminate the Group Policy in whole, and may terminate Insurance for any class or group of Members, at any time by giving us written notice.

Benefits under the Group Policy are limited to its terms, including any valid amendment. No change or amendment will be valid unless it is approved in writing by one of our executive officers and given to the Policyholder for attachment to the Group Policy. If the terms of the Certificate differ from the Group Policy, the terms stated in the Group Policy will govern. The Policyholder, your Employer and their respective employees or representatives have no right or authority to change or amend the Group Policy or to waive any of its terms or provisions without our signed written approval.

We may change the Group Policy in whole or in part when any change or clarification in law or governmental regulation affects our obligations under the Group Policy, or with the Policyholder's consent.

Any such change or amendment of the Group Policy may apply to current or future Members or to any separate classes or groups thereof.

DEFINITIONS

Active Work and Actively At Work mean performing the material duties of your own occupation at your Employer's usual place of business.

Contributory means Insurance is elective and Members pay all or part of the premium for Insurance.

Dental Professional means any of the following who is acting within the scope of the license:

1. A doctor of dental medicine (D.M.D.);
2. A doctor of dental surgery (D.D.S.);
3. A dental hygienist; or
4. A denturist.

Dental Professional does not include: the Member; or the spouse, brother, sister, parent or child of either the Member or the Member's Dependent.

Eligibility Waiting Period means the period you must be a Member before you become eligible for Insurance. See **Coverage Features**.

Employer means an employer (including approved affiliates and subsidiaries) for which coverage under the Group Policy is approved in writing by us.

Group Policy means the group dental insurance policy issued by us to the Policyholder and identified by the Group Policy Number.

Incur, Incurs, Incurred and Incurred Date mean, with respect to a Dental Expense, the date the services or supplies are provided to you, except:

1. Bridgework, a crown, or onlay work is incurred on the date the tooth or teeth are prepared;
2. Placement or modification of a full or partial denture is incurred on the date the impression is made; and;
3. Root canal therapy is incurred on the date the pulp chamber is opened.

Injury means an injury to your body.

Insurance means insurance under the Group Policy.

Insured Person means the Member or any Dependent who is insured under the Group Policy.

Negotiated Fee Schedule means the schedule of charges for dental services and supplies which has been agreed upon by the preferred provider organization and the PPO Dental Professionals who are participating in the preferred provider organization.

Noncontributory means (a) Insurance is nonelective and the Policyholder or Employer pay the entire premium for Insurance; or (b) the Policyholder or Employer require all eligible Members to have Insurance and to pay all or part of the premium for Insurance.

Non-PPO Dental Professional means a Dental Professional who is not participating in the preferred provider organization shown in the **Coverage Features**.

PPO Dental Professional means a Dental Professional who is participating in the preferred provider organization shown in the **Coverage Features**.

Periodontal Splint means any appliance designed to retain teeth in position, and includes multiple abutments for fixed bridgework.

Plan Administrator means the person designated by the Employer to maintain the coverage under the Group Policy.

Pregnancy means your pregnancy, childbirth or related medical conditions, including complications of pregnancy.

Prior Plan means your Employer's group dental plan in effect on the day before the effective date of your Employer's coverage under the Group Policy and which is replaced by the Group Policy.

Reasonable and Customary Charge means the lesser of:

1. The Dental Professional's usual charge for the same services or supplies in the absence of dental insurance coverage; and
2. The charge customarily billed to private patients for the same or similar dental services or supplies by Dental Professionals with similar training and experience in the same Geographically Significant Area. Geographically Significant Area means an area which we determine is large enough to provide a representative base of charges for the same or similar dental services or supplies.

The Reasonable and Customary Charge is determined every six months. The Reasonable and Customary Charge is based upon national and regional claims statistics which compile billed fees that Dental Professionals customarily charge for dental services and supplies.

Sickness means your sickness, illness, or disease.

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