Voluntary Group Dental Insurance

Employee Benefit Booklet

THE BARTER FOUNDATION INC.

FG1D0373-0001

Class 1-01

Products and services marketed under the Dearborn National™ brand and the star logo are underwritten and/or provided by Fort Dearborn Life Insurance Company® (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands and Guam.

05.03.2012

FORT DEARBORN LIFE
Insurance Company®

Group Dental Insurance Certificate

Fort Dearborn Life Insurance Company

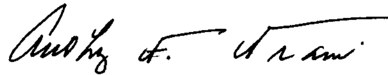
Chicago, Illinois

Administrative Office:

1020 31st Street

Downers Grove, IL 60515

Fort Dearborn Life Insurance Company hereby certifies that it has issued a Group Dental Insurance Policy (herein called the "Plan") for the Employees of the Policyholder named on this Certificate. Subject to the provisions of the Plan, each Employee to whom a Fort Dearborn Life Identification Card is issued, together with his eligible Dependents for whom application is initially made and accepted, shall have coverage under the Plan, beginning on the effective date shown on the Schedule of Benefits, if the Policyholder makes timely payment of total premium due to FDL. Issuance of this Certificate by FDL does not waive the eligibility and effective date provisions stated in the Plan.



President

The Schedule of Benefits enclosed with this Certificate indicates benefit percentages, Deductibles, maximums, and other terms and conditions which apply to coverage under the **Plan**. The Schedule of Benefits specifies benefits for:

VOLUNTARY DENTAL BENEFITS

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SCHEDULE OF BENEFITS

Benefits described in this Certificate apply only if also listed here.

Revised May 1, 2012

Policyholder:	THE BARTER FOUNDATION INC.
Policy Number:	FG1D0373-0001
Effective Date:	May 1, 2010
Class:	All active full-time employees.
Employee and Dependent eligibility:	All active full-time employees.
Waiting Period:	Following completion of 90 days
Dependent child age limit:	26
Predetermination amount:	$0
Deductible each Calendar Year for each Participant:	$50
Family deductible:	$150
Probationary Period* for Allowable Expenses in:	
Benefit Categories 1,2,3,4,5,7	None
Benefit Categories 6,8,9	12 Months
Benefit Category 11	12 Months

* Probationary Period is the amount of time a Participant must have been continuously covered under this contract before he is eligible for certain benefits.

Three-month deductible carryover: No

DENTAL BENEFITS

DENTAL EXPENSE BENEFIT	ANNUAL DEDUCTIBLE AMOUNT	
	IN-NETWORK	**OUT-OF-NETWORK**
Annual Deductible Amount		
Individual	$50	$50
Family	$150	$150
Note: Deductible waived for Preventive and Diagnostic Care Services. Covered dental expenses incurred toward the deductible amount apply to both the In-Network and Out-of-Network Plan.		
Benefit Categories	**Covered Percentage of Allowable Expenses**	
1. Diagnostic and Preventive Care	100%	100%
2. Miscellaneous Services	100%	100%
3. Restorative Services	80%	80%
4. General Services	80%	80%
5. Endodontic Services	50%	50%
6. Periodontal Services	50%	50%
7. Oral Surgery Services	50%	50%
8. Crowns, Inlays/Onlays Services	50%	50%
9. Prosthodontic Services	50%	50%
11.Orthodontia (Child Only) **Note: The limiting Age for Children is 19**	50%	50%

MAXIMUM CALENDAR YEAR BENEFITS		**MAXIMUM LIFETIME BENEFITS**	
Covered Dental Expenses (excluding Orthodontia)	$1,000	Implant Services	$0
Orthodontic Services	$0	Orthodontic Services	$1,000
Temporomandibular Joint (TMJ) Services	$0	Temporomandibular Joint (TMJ) Services	$0
Note: Amounts applied to the benefit maximums will apply to both the In-Network and Out-of-Network Plans.			

INTRODUCTION

EXPLANATION

This Plan has been designed and selected by the Policyholder as one of the benefits of Your employment. Please read this Certificate carefully so You will be aware of the benefits and requirements of the Plan. This Certificate summarizes Plan benefits and provisions for Dental Benefits.

Benefits for Covered Dental Services described in this Certificate are determined by the benefit categories listed below. **You are covered only for those benefit categories selected by the Policyholder and shown on the Schedule of Benefits.** The benefit percentage to be applied to each benefit category is shown on the Schedule of Benefits.

- Diagnostic and Preventive Care Services
- Miscellaneous Services
- Restorative Services
- General Services
- Endodontic Services
- Periodontal Services
- Oral Surgery Services
- Crowns, Inlays/Onlays Services
- Prosthodontic Services
- Orthodontic Services

Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

IDENTIFICATION CARD

You will be issued an Identification Card. This card identifies You and any covered family members as Participants in the FDL Dental Benefits Plan. Your card contains important information about You, the Policyholder, and the benefits to which You are entitled.

Always remember to carry Your Identification Card with You and present it to Your Dentist when receiving dental services or supplies. Dentists will use the information on Your card to file claims for You and any covered family members. Any time a change in Your family takes place, it may be necessary for a new Identification Card to be issued to You. Contact the Policyholder for more information. Upon receipt of the changed information, a new Identification Card will be issued and forwarded to the Policyholder for distribution to You.

WHO GETS BENEFITS

WHO IS ELIGIBLE FOR COVERAGE?

Employees and Retirees who are in a class named in the Application and their Dependents are eligible for coverage under the Plan. Only individuals who meet the following eligibility requirements may apply for coverage under the Plan.

Employee Eligibility

You are eligible for coverage under the Plan if You are an Employee in a class shown on the Schedule of Benefits and You have completed the waiting period, if any. You may apply for coverage for Yourself and Your Eligible Dependents on or before Your Eligibility Date.

Dependent Eligibility

For the purposes of this provision, an eligible Dependent includes:

1. an eligible Employee's lawful spouse, including a spouse or former spouse for whom the Employee has received a court order to maintain financial responsibility for providing health insurance; and/or
2. any unmarried child of an eligible Employee who is within the age limits set forth in the Schedule of Benefits, and is not in active military service, including:
   a. the Employee's natural child; or
   b. the Employee's legally adopted child;
   c. the Employee's stepchild; or
   d. a child for whom the Employee has received a court order to maintain financial responsibility for providing health insurance.

Eligibility will continue past the limiting age for eligible Dependent children who are primarily dependent upon the Employee for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. Proof of such incapacity must be provided to Us upon request.

A person cannot be insured as an Employee and also as a Dependent under the Plan. If both the husband and the wife are covered as Employees under the Plan, only one may enroll for dental coverage on Dependent child(ren).

Retiree Eligibility

If you are a retired Employee and retired Employees are listed as an eligible class on the Application, You are eligible to continue Your coverage under the Plan, provided You were covered under the Plan as an Employee on the date of retirement. You may not enroll for dental coverage under the Plan at retirement.

Eligibility Date

The Eligibility Date is the date a person becomes eligible to be covered under the Plan, as follows:

1. For an Employee hired after the Policy Effective Date, the date the Employee completes the waiting period (i.e. the number of days of continuous employment required by the Policyholder for coverage under the Plan).
2. For an Employee hired prior to the Policy Effective Date, the Eligibility Date will be the Policy Effective Date. The waiting period will be waived unless indicated in the Application.
3. For a Dependent who meets the definition of an Eligible Dependent on the Employee's Eligibility Date, the Employee's Eligibility Date.
4. For a Dependent of an eligible Employee acquired while he is covered under the Plan, the date the Employee acquires the Dependent, as follows:
   a. the date of marriage,

b. the date of birth,

c. the date of placement for adoption;

d. the date of issuance of a court order requiring the Employee to maintain financial responsibility for health coverage for a Dependent spouse or child.

WHEN DOES COVERAGE BEGIN?

The effective date is the date coverage for a Participant actually begins. It may be different from the Eligibility Date.

Non-Contributory Coverage

Noncontributory benefits under the Plan will become effective for an Employee who is Actively at Work on the day following completion of the waiting period, if any, set forth in the Application.

Contributory Coverage

Contributory coverage will become effective as follows, provided the Employee is Actively at Work on that date:

1. If the enrollment form is signed on or before the end of the waiting period, if any, as stated in the Application, the coverage will become effective on the day following completion of the waiting period.
2. If the enrollment form is signed after the end of the waiting period, but within 31days after that day, the coverage will become effective the date the Employee signs the enrollment form.

Dependent Coverage

Covered Employees may add Dependent children at any time, up to age 5, and coverage will become effective on the first of the month following receipt by FDL of application and the required premium.

Coverage for a natural, step or adopted Dependent child who becomes eligible after the Employee's coverage effective date is automatically effective on the Dependent's Eligibility Date for 31 days. To continue coverage beyond the 31 day period, the Employee must submit application and any applicable premium within the 31 day period.

Covered Employees may add a newly acquired Dependent spouse, and if the application is received by FDL within 31 days of the Dependent's Eligibility Date, the coverage will become effective on the Dependent's Eligibility Date.

Deferred Effective Date

An Employee must be Actively at Work on the date his coverage under the Plan is scheduled to begin. If:

1. he is absent from Active Work on the date such coverage would otherwise become effective; and
2. his absence is caused by an injury, illness or layoff,

the effective date of coverage will be deferred until the first day he returns to Active Work. An Employee will be considered Actively at Work if he was actually at work on the day immediately preceding:

1. a weekend (except for one or both of these days if they are scheduled work days);
2. a holiday (except when such holiday is a scheduled work day);
3. a paid vacation;
4. any nonscheduled work day.

REPORTING CHANGES IN YOUR FAMILY

You should notify the Policyholder promptly if any of the following events take place:

1. You marry or divorce,
2. A child is acquired, by marriage, new birth or adoption,
3. A child marries or reaches the age limit described below,
4. A Participant in Your family dies, or
5. You receive a court order to provide health coverage for Your child or spouse.

You should promptly notify FDL by filling out a form which has been furnished to the Policyholder. If You are adding a Dependent, You must submit an application and the coverage will become effective as described in the Dependent Coverage effective date provision above.

WHEN DOES COVERAGE END?

FDL is not required to give You notice of termination of coverage. FDL will not always know of the events causing termination until after the events have occurred.

Termination of Coverage

Insurance coverage will end for You on the earliest of:

1. the date You are no longer a member of a covered class; or
2. the date the Plan is canceled; or
3. the effective date of an amendment to this Plan which terminates insurance for the class to which You belong; or
4. the date You stop making any required contribution toward payment of premiums; or
5. the last day of the insurance month during which You are no longer Actively at Work; and
6. for Dependents, the date a Dependent child or spouse is no longer eligible for coverage as defined in this Certificate.

If coverage for a Dependent terminates because of loss of eligibility as listed above, coverage ends automatically and benefits for expenses incurred after termination are not available. If We pay benefits prior to our receiving notification of Your termination, We will request a refund. If Your coverage or that of Your Dependents ends, You may be eligible to continue coverage at Your own expense. Review carefully the **CONTINUATION OF COVERAGE RIGHTS UNDER COBRA** Notice at the back of this Certificate.

Termination of the Group

The coverage of all Participants will terminate in accordance with the terms of the Plan if the group is terminated.

LOSS OF ELIGIBILITY

If Your coverage ends due to loss of eligibility, You must meet all the requirements of a new Employee if You are rehired at a later date.

HOW TO RECEIVE BENEFITS

DENTAL NETWORK OF AMERICA PPO DENTISTS

FDL has an arrangement with certain Preferred Providers (herein called Dental Network of America Dentists) to discount their charges for Covered Dental Services. You have the option of selecting a Preferred Provider or a Non-Preferred Provider. By choosing a Dental Network of America Dentist, Your out-of-pocket expenses are generally less than the amount owed if Non-Preferred Providers had been used.

When You receive care from a Preferred Provider:

1. confirm the Dentist's continued Dental Network of America PPO Network participation at each visit;
2. Your Dentist is responsible for submitting Your claim to FDL. You do not need to submit claims for Covered Dental Services; and
3. you are not responsible for charges that exceed the Allowable Amount.

You are responsible for:

1. any Deductibles;
2. any amounts in excess of maximums;
3. Coinsurance Amounts; and
4. services that are limited or not covered by the Plan.

If Your Dentist is not a Preferred Provider, You may be responsible for filing Your claim, as described in **CLAIMS FILING PROCEDURES, Who Files Claims** subsection, and for payment in full at the time services are rendered.

CLAIM FILING PROCEDURES

Filing of Claims Required

Notice of Claim

You must give written notice to FDL within 90 days, or as soon as reasonably possible, after any Participant receives services for which benefits are provided under the Plan. Failure to give notice within this time will not invalidate or reduce any claim if You show that it was not reasonably possible to give notice and that notice was given as soon as it was reasonably possible.

Claim Forms

When FDL receives notice of claim, it will furnish to You, or to the Policyholder for delivery to You, or the Dentist, the dental claim forms that are usually furnished by it for filing Proof of Loss. Claim forms may also be obtained by accessing the FDL website at www.FDL-life.com.

If the forms are not furnished within 15 days after receipt of notice by FDL, You have complied with the requirements of the Plan for Proof of Loss by submitting, within the time fixed under the Plan for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

FDL must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits.

Who Files Claims

Provider -filed claims

Preferred Providers are responsible for submitting Your claims directly to FDL for services provided to You or any of Your covered Dependents. To assist Dentists in filing Your claims, You should carry Your Identification Card with You.

Participant-filed claims

If Your Dentist is not a Preferred Provider, You may need to submit Your claim to FDL using a form provided by FDL. The Policyholder should have a supply of dental claim forms. It is important to file each Participant's expenses separately because Deductibles, maximum benefits, and other provisions are applied for each Participant separately.

Include itemized bills from the Dentist printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

Who Receives Payment

Benefit payments will be made directly to the Dentists when they bill FDL. Written agreements between Dental Network of America and some Dentists may require payment directly to them, even if You file the claim. Any benefits payable to You, if unpaid at Your death, will be paid to Your beneficiary or to Your estate if no beneficiary is named.

Except as provided in the section **ASSIGNMENT AND PAYMENT OF BENEFITS**, rights and benefits under this Plan shall not be assignable, either before or after services and supplies are provided.

Benefits for services provided to Your minor Dependent child may be paid to a third party if:

1. the third party is named in a court order as managing or possessory conservator of the child; and
2. FDL has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to FDL, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator or guardian of the estate of the child.

FDL may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to You or Your Dentist, or deduction by FDL from benefit payments of amounts owed to FDL will be considered in satisfaction of its obligations to You under this Plan.

An *Explanation of Benefits* summary is sent to You so You will know what has been paid.

When to Submit Claims

All claims for benefits under this Plan must be properly submitted within 90 days of the date You receive the services or supplies. Claims not submitted and received by FDL within 12 months after the date You receive the services or supplies will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by FDL

A claim will be considered received by FDL for processing upon actual delivery to the FDL Administrative Office in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied, or FDL may contact either You or the Dentist for the additional information.

Review of Claim Determinations

Claim Determinations

When FDL receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Plan provisions. FDL will render an initial decision to pay or deny a claim within 30 days of receipt of the claim. If FDL requires further information in order to process the claim, we will request it within that 30-day period.

If a Claim Is Denied or Not Paid in Full

On occasion, FDL may deny all or part of Your claim. There are a number of reasons why this may happen. First, read the *Explanation of Benefits* summary prepared by FDL; then, review this Certificate to see whether You understand the reason for the determination. If You have additional information that You believe could change the decision, send it to FDL and request a review of the decision. Include Your full name, group and subscriber numbers with the request. If the claim is denied in whole or in part, You will receive a written notice, from FDL with the following information, if applicable:

1. the reasons for denial;
2. a reference to the dental care plan provision on which the denial is based;
3. a description of additional information which may be necessary to complete the claim and an explanation of why such information is necessary; and
4. an explanation of how You may have the claim reviewed by FDL if You do not agree with the denial.

Right to Review Claim Determinations

You have the right to seek and obtain a full and fair review by FDL of any determination of a claim or any other determination made by FDL of Your benefits under this Plan.

If You believe FDL incorrectly denied all or part of Your benefits, You may have Your claim reviewed. FDL will review its decision in accordance with the following procedure:

1. within 180 days after You receive notice of a denial or partial denial, write to FDL's Administrative Office. FDL will need to know the reasons why You do not agree with the denial or partial denial.
2. You may also designate a representative to act for You in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about You except to Your authorized representative.
3. FDL will honor telephone requests for information; however, such inquiries will not constitute a request for review.
4. You and Your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical/dental information within 180 days after You receive notice of a denial or partial denial. FDL will give You a written decision within 60 days after it receives Your request for review.
5. if You have any questions about the claims procedures or the review procedure, write to FDL or call the number on Your Identification Card.
6. if You have a claim for benefits which is denied or ignored, in whole or in part, and Your Plan is governed by the Employee Retirement Income Security Act (ERISA), You may file suit under 502 (a) of ERISA.

Interpretation of the Policyholder's Plan Provisions

The operation and administration of the Plan require uniformity regarding the intent of the Plan and the interpretation of the Plan provisions. The Policyholder has given FDL full and complete authority and discretion to make decisions regarding the Plan provisions and determining questions of eligibility and benefits. Any decision by FDL which is not arbitrary or capricious shall be final and conclusive, subject to any applicable State and federal law.

Actions Against FDL

No lawsuit or action in law or equity may be brought by You or on Your behalf unless:

1. You first have fully complied with all of the provisions of the Plan, including all of the procedures and requirements of the **CLAIM FILING PROCEDURES** and **Review of Claim Determinations** subsection; and
2. FDL has either denied in writing Your request for review of the claim determination or has not provided a written response to Your request for review within 60 days after receiving the request; and
3. such lawsuit or action is brought within three years from the expiration of the time within which written Proof of Loss is required to be furnished under the Plan.

DENTAL BENEFITS PROVIDED

Benefits are payable for Covered Dental Services and supplies that are considered Dentally Necessary. The benefit percentage to be applied to each benefit category is shown on the Schedule of Benefits.

Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

HOW BENEFITS ARE CALCULATED

Benefits are paid based on the Coinsurance Amount percentage shown on the Schedule of Benefits for each category as it is applied to the Allowable Amount. To determine benefits, the Deductible (if not previously satisfied) is subtracted from the Allowable Amount for a category. This amount is then multiplied by the Coinsurance Amount percentage for that category. The resulting total is the benefit payable by FDL.

The remaining unpaid amounts, including any excess portion above the Allowable Amount, any Deductible and the Coinsurance Amount percentage will be Your responsibility to pay to Your Dentist.

DEDUCTIBLE

The Deductible shown on the Schedule of Benefits will be subtracted once during each Calendar Year from the total eligible Covered Dental Services incurred for that Calendar Year. It will apply to each benefit category, unless the Schedule of Benefits indicates it is waived for a particular benefit category. It will apply to each Participant. The following exceptions will apply:

1. if "Three-Month Deductible Carryover" is shown on the Schedule of Benefits, any Covered Dental Services incurred during the last three months of a Calendar Year and applied toward satisfaction of the Deductible for that Calendar Year, may be applied toward satisfaction of that Deductible for the following Calendar Year.
2. when any number of family Participants have satisfied the Family Deductible for a Calendar Year, any other Participants under Your coverage will not have to satisfy a Deductible for that Calendar Year.

ALLOWABLE AMOUNT DETERMINATION

In determining the Allowable Amount, FDL will consider such factors as Your Dentist's usual fee and fees charged by other Dentists in the area with similar training and experience and any special circumstances. The portion of the charges by Your Dentist that exceeds the Allowable Amount of FDL will be Your responsibility to pay to Your Dentist. In other words, a certain amount of the Dentist's charge may not be considered by FDL for benefits. Refer to the **DEFINITIONS** section for a detailed explanation of Allowable Amount.

CURRENT DENTAL TERMINOLOGY (CDT)

The most recent edition of the manual published by the American Dental Association (ADA) entitled Current Dental Terminology and Procedure Codes (CDT) is used when classifying dental services.

The Allowable Amount for a Covered Dental Service will be based on the most inclusive procedure codes.

COURSE OF TREATMENT

Your Dentist may decide on a planned series of dental procedures which a dental exam shows You need. In cases where there is more than one professionally acceptable Course of Treatment, benefits will be covered for the most economical procedures.

PREDETERMINATION OF BENEFITS

The Schedule of Benefits may indicate a "Predetermination Amount." If a Course of Treatment for non-emergency services can reasonably be expected to involve Covered Dental Services in excess of this predetermination amount, a description of the procedures to be performed and an estimate of the Dentist's charge should be filed with and predetermined by FDL prior to the commencement of treatment.

FDL may request copies of existing x-rays, photographs, models, and any other records used by the Dentist in developing the Course of Treatment. FDL will review the reports and materials, taking into consideration alternative Courses of Treatment. FDL will notify You and the Dentist of the benefits to be provided under the Plan.

Predetermination gives You and Your Dentist the opportunity to know the extent of the benefits available. Benefit payments may be reduced based on any claims paid after a predetermination estimate is provided.

MAXIMUM BENEFITS

Maximum Calendar Year Benefits

The maximum amount of benefits available for all combined Covered Dental Services for a Calendar Year for any one Participant is the amount shown on the Schedule of Benefits.

Depending on the terms of the Plan, it may also include any benefits provided under the Policyholder's dental plan with another carrier prior to the Participant's effective date of coverage under this Plan.

Maximum Lifetime Benefits

The maximum lifetime benefits available for any one Participant for Orthodontic, Implant or Temporomandibular Joint (TMJ) Services is the amount shown on the Schedule of Benefits if applicable to Your coverage. Maximum lifetime benefit amounts do not apply to any other Covered Dental Services.

Depending on the terms of the Plan, it may also include any benefits provided under the Policyholder's dental plan with another carrier prior to the Participant's effective date of coverage under this Plan.

CHANGES IN BENEFITS

Changes in benefits will apply to all services provided to each Participant under this Plan.

Benefits for Covered Dental Services incurred during a Course of Treatment which begins before the change will be the benefits in effect on the date the Course of Treatment was started.

COVERED DENTAL SERVICES

The Plan will provide benefits for the following Covered Dental Services, subject to the limitations and Exclusions described in this Certificate. **You are covered only for those benefit categories shown on the Schedule of Benefits**. The benefit percentage applicable to each benefit category is shown on the Schedule of Benefits.

The Listing of Covered Dental Services is a complete list of Covered Dental Services. We will not pay benefits for expenses incurred for any service not listed below, unless We agree to accept an unlisted service as a Covered Dental Service. We will not accept any unlisted service which is not similar to, or which does not accomplish a result similar to, a listed service. The choice of whether or not to accept an unlisted service is solely Ours. If We do accept an unlisted service as a Covered Dental Service, benefits will be payable on a basis consistent with benefits for similar Covered Dental Services which would provide the least costly adequate treatment of a Participant's dental condition according to broadly accepted standards of professional dental care as determined by Us.

Diagnostic and Preventive Care

Services that are used to prevent dental disease or to determine the nature or cause of a dental disease:

a. Routine oral evaluations (limited to two per Calendar Year).

b. X-rays (dental radiographs):

    i. full mouth or panorex x-ray limited to once every 36 months;

    ii. bitewing limited to 4 horizontal films or 8 vertical films twice per Calendar Year; and

    iii. other x-rays as necessary for diagnosis (except in connection with a program of orthodontics).

c. Professional cleaning, scaling and polishing teeth (prophylaxis) limited to two per Calendar Year.

d. Fluoride treatment (topical application), limited to two per Calendar Year for Participants up to age 19.

Miscellaneous Services

a. Sealants, limited to one per unrestored permanent molar for Participants up to age 14.

b. Space maintainers for Participants up to age 19.

c. Pulp vitality tests.

d. Palliative (emergency) treatment to relieve dental pain except when performed in conjunction with definitive dental treatment.

Restorative Services

The process of replacing, by artificial means, a part of a tooth that has been damaged by disease (e.g. cavities). Tooth preparation, all adhesive (including amalgam bonding agents), liners and bases are included as part of the restoration.

a. Amalgam restorations limited to once per surface per tooth in any Calendar Year.

b. Pin retention, per tooth, in conjunction with the restoration.

c. Composite restorations limited to once per surface per tooth per Calendar Year.

d. Simple tooth extraction.

General Services

a. Intravenous sedation.

b. General Anesthesia.

c. House call.

d. Injection of Antibiotic drugs.

e. Stainless steel crowns limited to one per tooth in a 60 month period and not to be used as a temporary crown.

Endodontic Services

Dental Services for prevention, diagnosis and treatment of diseases and injuries affecting the tooth and dental pulp.

a. Root canal therapy including treatment plan, clinical procedures, pre and post-operative radiographs and follow-up care.

b. Direct pulp cap.

c. Apicoectomy/periradicular services.

d. Apexification/recalcification.

e. Retrograde filling.

f. Root amputation/hemisection.

g. Therapeutic pulpotomy.

h. Gross pulpal debridement.

Periodontal Services

Dental Services that treat diseases of the tissues that surround and support the teeth (e.g. gums and supporting bone) limited to two exams per Calendar Year. Periodontal maintenance includes the following:

a. Periodontal scaling and root planning limited to one time per quadrant per Calendar Year;

b. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to one time per Calendar Year;

c. Gingivectomy or gingivoplasty limited to one time per quadrant per Calendar Year;

d. Gingival flap procedure (includes root planning) limited to one time per quadrant per Calendar Year;

e. Osseous surgery, including flap entry with closure limited to one time per quadrant per Calendar Year;

f. Osseous grafts limited to one time per site per Calendar Year; and

g. Soft tissue grafts (includes donor site).

Oral Surgery Services

Dental Services for the treatment of certain dental conditions by operative or cutting procedures.

a. Surgical tooth extractions.

b. Alveoloplasty.

c. Vestibuloplasty.

d. Other Dentally Necessary surgical procedures.

Crowns, Inlays/Onlays Services

Dental services resulting from extensive disease or fracture limited to one per tooth in a 60 month period.

a. Prefabricated post and cores.

b. Cast post and cores.

c. Crown, inlays/onlays repairs

d. Recementation of inlays/onlays, crowns.

Benefits include the replacement of a lost or defective crown whether placement was under this Plan or under any prior dental coverage and even if the original crown was stainless steel.

Benefits will not be provided for replacement of dentures, crowns, inlays/onlays, removable or fixed prostheses, and dental restorations due to theft, misplacement, or loss; or for replacement of dentures, removable or fixed prostheses, and dental restorations for any other reason within 60 months after receiving such dentures, prostheses, or restorations.

Prosthodontic Services

Dental services that restore and maintain the oral function, comfort and health of a patient by replacing missing teeth and surrounding tissue with artificial substitute. Covered Services include bridges, partial dentures and complete dentures.

a. Initial installation of bridgework (including inlays and crowns as abutments) limited to once per tooth in any 60 month period, whether placement was under this Plan or under any prior dental coverage.

    i. Bridge repair.

    ii. Recementing a bridge.

    iii. Post and core buildup.

b. Initial installation of removable complete, immediate or partial dentures (including any adjustments, relines or rebases during the 6 month period following installation) limited to once in any 60 month period, whether placement was under this Plan or under any prior dental coverage.

    Benefits are available for the replacement of complete or partial dentures, but only if the appliance is 60 months old or older and cannot be made serviceable.

c. Adjustments limited to 3 times per appliance in any Calendar Year.

d. Repairs.

e. Addition of tooth or clasp (unless additions are completed on the same date as replacement partials/dentures) limited to a lifetime maximum of once per tooth.

f. Denture rebase and reline procedures limited to one in any 36 month period.

ORTHODONTIA

Orthodontic Services

Orthodontic procedures and treatment include examination records, tooth guidance and repositioning (straightening) of the teeth for Participants covered for Orthodontics as shown on Your Schedule of Benefits.

Orthodontic services are paid over the course of treatment, up to the maximum lifetime orthodontic benefit and are not subject to the Calendar Year benefit limit.

Orthodontic lifetime benefits may be reduced by the amount paid by the previous Dental carrier if the Policyholder elects to provide FDL with the dollar maximum used while covered under the previous carrier's Plan.

Orthodontic services include:

a. Diagnostic orthodontic records limited to a lifetime maximum of once per Participant;

b. Limited, interceptive and comprehensive orthodontic treatment;

c. Minor treatment to control harmful habits;

d. Orthodontic retention limited to a lifetime maximum of one appliance per Participant.

Orthodontic treatment is started on the date the bands or appliances are inserted. A Covered Dental Service for orthodontic evaluation will be considered started and completed on the date the service is actually performed.

EXCLUSIONS

In addition to those benefit maximums and limitations described in DENTAL **BENEFITS PROVIDED***, the benefits of the Plan are not available for any Covered Dental Services incurred:*

1. In connection with an occupational illness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
2. For which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for dental assistance (Medicaid); provided, however, this exclusion shall not be applicable to any coverage held by the Participant for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
3. As a result of disease contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.
4. Primarily for cosmetic purposes, including but not limited to bleaching teeth, grafts to improve esthetics, except for:
   a. Services provided for correction of defects incurred through traumatic injuries sustained by the Participant while covered under the Plan; or
   b. Covered orthodontic diagnostic procedures and treatment; or
   c. Services provided to a newborn child which are necessary for treatment or correction of congenital defects.
5. For services or supplies which do not meet accepted standards of dental practices.
6. For services provided or received for:
   a. behavior management; or
   b. consultation purposes.
7. For Benefits for an alternate Course of Treatment which exceeds the most economical procedures.
8. For personalized complete or partial dentures, overdentures, and their related procedures, or other specialized techniques not normally taught in regular dental school classes; for services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are Experimental/Investigational in nature or not fully approved by a Council of the America Dental Association; and for services or supplies not Dentally Necessary.
9. For treatment provided before the effective date of a Participant's coverage or after termination of coverage under this Plan.
10. For appliances, materials, restorations, or special equipment used to increase vertical dimension, correct or restore the occlusion except as may be provided on the Schedule of Benefits.
11. To correct temporomandibular joint (TMJ) dysfunction or pain syndromes except as may be provided on the Schedule of Benefits.
12. For which benefits are otherwise provided under inpatient hospital expense or medical-surgical expense coverage under the medical benefits of the health benefit plan.
13. For treatment by other than a Dentist, except that x-rays, scaling, cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist, if the treatment is provided under the supervision and guidance of the Dentist.
14. For replacement or repair of an orthodontic appliance.

15. For services or supplies when:
    a. no charge is made;
    b. the Participant is not legally obligated to pay;
    c. no charge would be made in the absence of this or similar dental coverage;
    d. “discounts” or waiver of a Deductible or Coinsurance Amounts are offered;
    e. treatment is received by a Dentist who is related to the Participant by blood or marriage; or
    f. treatment is provided through a medical department, clinic, or similar facility furnished or maintained by the Policyholder.
16. For a duplicate prosthetic device, other duplicate appliances or duplicate dental restoration.
17. For:
    a. dietary and oral hygiene instruction, a plaque control program and tobacco use counseling; and
    b. For prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
18. For any charge:
    a. Resulting from the failure of a Participant to keep a scheduled visit with a Dentist; or
    b. For completion of any insurance forms; or
    c. For telephone consultations; or
    d. For records or x-rays necessary for FDL to make a benefit determination.
19. For splinting, grafting and preparation associated with Implants, if “Implants” is not indicated on Your Schedule of Benefits.
20. For splinting of teeth, including double abutments for prosthetic abutments.
21. For Accidental Injuries including tooth transplantation.
22. For pin retention **not** performed on the same date of service and in conjunction with a covered amalgam or composite restoration.
23. For administration of any local anesthesia, and necessary infection control as required by OSHA, state and federal mandates billed separately.
24. For palliative (emergency) treatment performed in conjunction with definitive dental treatment.
25. For indirect pulp capping.
26. For athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/ malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
27. For bacteriological studies for determination of pathologic agents and soft tissue allograft.
28. For biologic materials, cytology sample collection and histopathological examinations.
29. For canal preparation and fitting of prefabricated dowel and post if billed separately.
30. For caries susceptibility tests.
31. For chemical treatments, localized delivery of chemotherapeutic agents without history of active periodontal therapy.
32. For crowns to restore occlusion or incisal edges due to bruxism or harmful habits.
33. For desensitizing medicaments and/or their application.

DEFINITIONS

This section tells You the meaning of special words and phrases used in this Certificate. To help You recognize these special words and phrases, the first letter of each word, or each word in the phrase, is capitalized wherever it appears.

Actively at Work means that You are:

1. performing the normal duties of Your occupation; and
2. working the number of hours set forth in the Application.

Allowable Amount means the maximum amount determined by FDL to be payable for a particular service, supply, or procedure. To calculate the Allowable Amount, FDL uses the most appropriate method in consideration of the Dentist and/or type of service as follows:

1. For Preferred Providers, the Allowable Amount is the lesser of:
   a. the Maximum Allowance for the service or supply; and
   b. the amount charged by the Preferred Provider for the service or supply.
2. For non-Preferred Providers, the Allowable Amount is the lesser of:
   a. the Reasonable and Customary Charge for the service or supply; and
   b. the amount charged by the provider for the service or supply

Unless otherwise stipulated by a contract between the Dentist and carrier:

1. an Allowable Amount will be established by identifying Dentists with similar experience or skill in order to establish the applicable amount for the procedure, services, or supplies.
2. for multiple surgical procedures performed in the same operative area, the Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus an additional Allowable Amount for covered supplies or services.
3. when a less expensive professionally acceptable service, supply, or procedure is available, the Allowable Amount will be based upon the least expensive service. This is not a determination of Dental Necessity, but merely a contractual benefit allowance.

The Allowable Amount for all Covered Dental Services also includes the administration of any local anesthesia and necessary infection control as required by state and federal mandates.

Application means the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the Policyholder applied. The Application is attached to and forms a part of this Policy, and shall include any subsequent amendments to the Application.

Calendar Year means the period commencing each January 1 and ending on the next succeeding December 31, inclusive.

Coinsurance Amount means the dollar amount of Covered Dental services eligible for benefits that are incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan.

Course of Treatment means any number of dental procedures or treatments performed by a Dentist in a planned series resulting from a dental examination concurrently revealing the need for such procedures or treatments.

Covered Dental Services means the professionally recognized dental services, supplies, or appliances for which a benefit is available to a Participant when provided by a Dentist on or after the Effective Date of coverage and for which the Participant acquires an obligation for payment.

Deductible means the dollar amount of Covered Dental Services that must be incurred by a Participant before benefits under the Plan will be available.

Dentally Necessary or **Dental Necessity** means those services, supplies, or appliances covered under the Plan which are:

1. essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the dental condition or injury; and
2. provided in accordance with and are consistent with generally accepted standards of dental practice in the United States; and
3. not primarily for the convenience of the Participant or his Dentist; and
4. the most economical supplies, appliances, or levels of dental service that are appropriate for the safe and effective treatment of the Participant.

FDL shall determine whether a service, supply, or appliance is Dentally Necessary and will consider the views of the state and national health communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Dentist may have prescribed treatment, such treatment may not be Dentally Necessary within this definition.

Dentist means a person, when acting within the scope of his license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree) and shall also include a person who is a Doctor of Medicine or a Doctor of Osteopathy.

Eligibility Date means the date the Participant satisfies the definition of either Employee or Dependent or Retiree and is in a class eligible for coverage under the Plan as described in **WHO GETS BENEFITS**.

Employee means an Actively at Work full-time employee whose principal employment is with the Policyholder, at the Policyholder's usual place of business or such place(s) that the Policyholder's normal course of business may require, who is Actively at Work for at least the number of hours per week as stated in the Application and is reported on the Policyholder's records for Social Security and withholding tax purposes.

Employer means, in addition to the person, firm, or institution named on the cover of this Certificate, one or more subsidiaries or affiliates, if any, listed on the Policy face page.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, *medical treatment* includes medical, surgical, or dental treatment. *Standard medical treatment* means the services or supplies that are in general use in the medical community in the United States, and:

1. have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
2. are appropriate for the hospital or facility in which they were performed; and
3. the Dentist has had the appropriate training and experience to provide the treatment or procedure.

FDL shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational within this definition.

Although a Dentist may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, FDL still may determine such services or supplies to be Experimental/ Investigational within this definition. Treatment provided as a part of a clinical trial or a research study is Experimental/ Investigational.

Maximum Allowance means the amount determined by FDL which Preferred Providers have agreed to accept as payment in full for a particular Covered Dental Service. These amounts may be amended from time to time by FDL.

Participant means an Employee, Dependent, or a retired Employee whose coverage has become effective under this Plan.

Policy means the contract between the Policyholder and FDL which provides group insurance benefits, including the attached Application and the group Certificate.

Policy Anniversary means the month, day, and year specified on the Application and the corresponding date in each year thereafter for as long as the Policy is in force.

Policy Effective Date means the date on which coverage under the Policy with FDL commences.

Policy Month means each succeeding monthly period, beginning on the Policy Date.

Policy Year means the first Policy Year beginning on the Policy Effective Date of coverage and ending 12 months later. Subsequent Policy Years begin on the Policy Anniversary dates and end 12 months later.

Policyholder means the person, firm, or institution named in the Policy, including any covered subsidiaries or affiliates named in the Policy.

Preferred Provider means a dentist, dental hygienist, dental office or medical center or any dental care provider who is a participant in FDL's Preferred Provider plan.

Proof of Loss means written evidence of a claim including:

1. the form on which the claim is made;
2. bills and statements reflecting dental services, supplies, and appliances furnished to a Participant and amounts charged for those services, supplies, and appliances that are covered by the claim; and
3. correct diagnosis and procedure code(s) for the services and items.

Reasonable and Customary means charges made for services or supplies essential to the care of the individual. Charges will be considered reasonable and customary if they are the amount normally charged by the provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the locality where the services or supplies are received. In determining whether charges are reasonably and customary, FDL considers the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill or experience.

You or Your means the Employee or Retiree to whom this Certificate has been delivered.

We, Our, Us means Fort Dearborn Life Insurance Company.

GENERAL INFORMATION

PARTICIPANT/DENTIST RELATIONSHIP

The choice of a Dentist is made solely by a Participant. FDL does not furnish services but only makes payment for Covered Dental Services incurred by Participants. FDL is not liable for any act or omission by any Dentist and FDL does not have any responsibility for a Dentist's failure or refusal to provide services to a Participant.

ASSIGNMENT AND PAYMENT OF BENEFITS

If a written assignment of benefits is made by a Participant to a Preferred Provider and the written assignment is delivered to FDL with the claim for benefits, FDL will make any payment directly to the Preferred Provider. Payment to the Preferred Provider discharges FDL's responsibility to the Participant for any benefits available under the Plan.

REFUND OF BENEFIT PAYMENTS

If FDL pays benefits for Covered Dental Services incurred by You or Your covered Dependents and it is found that the payment was more than it should have been, or was made in error, FDL has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, FDL may deduct any refund due it from any future benefit payment.

COORDINATION OF BENEFITS

The availability of benefits specified in this Policy is subject to Coordination of Benefits (COB) as described below. This COB provision applies to This Plan when a Participant has dental coverage under more than one Plan.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan shall not be reduced when This Plan determines its benefits before another Plan; but may be reduced when another Plan determines its benefits first.

Coordination of Benefits – Definitions

1. **Plan** means any group insurance or group-type coverage, whether insured or uninsured. This includes:
   a. group or blanket insurance;
   b. franchise insurance that terminates upon cessation of employment;
   c. group dental service plans and other group prepayment coverage;
   d. any coverage under labor-management trusteed arrangements, union welfare arrangements, or employer organization arrangements;
   e. governmental plans, or coverage required or provided by law.

   Plan does *not* include:

   a. any coverage held by the Participant for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
   b. a policy of dental insurance that is individually underwritten and individually issued;
   c. school accident type coverage; or
   d. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

   Each Policy or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.
2. **This Plan** means the part of this Policy that provides benefits for dental expenses.

3. **Primary Plan/Secondary Plan**

   The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the Participant. A *Primary Plan* is a Plan whose benefits are determined before those of the other Plan and without considering the other Plan's benefit. A *Secondary Plan* is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.

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

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

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

6. **We** or **Us** means Fort Dearborn Life Insurance Company (FDL).

Order of Benefit Determination Rules

1. ***General Information***

   When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless

   a. the other Plan has rules coordinating its benefits with those of This Plan, and

   b. both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.

2. ***Rules***

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

   a. ***Non-Dependent/Dependent*** – The benefits of the Plan which covers the Participant as an Employee, member, or subscriber are determined before those of the Plan which covers the Participant as a Dependent. However, if the Participant 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:

      i. secondary to the Plan covering the Participant as a Dependent; and

      ii. primary to the Plan covering the Participant as other than a Dependent (e.g., a retired Employee), then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant other than a Dependent.

   b. ***Dependent Child/Parents Not Separated or Divorced*** – Except as stated in paragraph c below, when This Plan and another Plan cover the same child as a Dependent of different parents:

      i. 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 Calendar Year; but

      ii. If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

      However, if the other Plan does not have the rule described in this paragraph b, but instead has a rule based on 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/Parents Separated or Divorced*** – If two or more Plans cover a Participant as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

      i. First, the Plan of the parent with custody of the child;

ii. Then, the Plan of the spouse of the parent with custody, if applicable;

iii. Finally, the Plan of the parent not having custody of the child.

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

d. ***Joint Custody*** **–** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in paragraph b.

e. ***Active/Inactive Employee*** – The benefits of a Plan which covers a Participant as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a Dependent of a person covered as a retired Employee and an Employee. 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 paragraph e does not apply.

f. ***Continuation Coverage*** – If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:

i. First, the benefits of a Plan covering the Participant as an Employee, member, or subscriber (or as that Participant's Dependent);

ii. Second, the benefits under the continuation coverage.

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 paragraph f does not apply.

g. ***Longer/Shorter Length of Coverage*** **–** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Participant for the shorter period of time.

Effect on the Benefits of this Plan

1. ***When This Section Applies***

This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

2. ***Reduction in this Plan's Benefits***

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

i. the benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

ii. the benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period.

b. If This Plan is a Secondary Plan, the total Allowable Expenses incurred for a Covered Person in any Claim Determination Period are the lessor of:

i. the benefits that would be payable under This Plan without applying the Coordination of Benefits Provision; and

ii. the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions.

In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

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

Right to Receive and Release Needed Information

We assume no obligation to discover the existence of another Plan, or the benefits available under the other Plan, if discovered. We have the right to decide what information We need to apply these COB rules. We may get needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person claiming benefits under This Plan must give Us any information concerning the existence of other Plans, the benefits thereof, and any other information needed to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again.

Right to Recovery

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

1. the persons we have paid or for whom We have paid;
2. insurance companies; or
3. Hospitals, Physicians, or Other Dentists; or
4. any other person or organization.

INFORMATION CONCERNING EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

If the Plan is part of an "employee welfare benefit plan" and "welfare plan" as those terms are defined in ERISA, the responsibilities of the Policyholder, You, and FDL include the following:

1. the Policyholder will furnish summary plan descriptions, annual reports, and summary annual reports to You and other plan participants and to the government as required by ERISA and its regulations.
2. FDL will furnish the Policyholder with this Certificate as a description of benefits available under the Plan. Upon written request by the Policyholder, FDL will send any information which FDL has that will aid the Policyholder in making its annual reports.
3. claims for benefits must be made in writing on a timely basis in accordance with the provisions of the Plan. Claim filing and claim review procedures are found in the **DENTAL BENEFITS PROVIDED** section of this Certificate.
4. FDL is not the ERISA "plan administrator" for benefits or activities pertaining to the Plan.
5. this Certificate is a Certificate of Coverage and not a Summary Plan Description.
6. the Policyholder has given FDL the authority and discretion to interpret the Plan provisions and to make eligibility and benefit determinations.

AMENDMENTS

The Plan may be amended or changed from time to time by the Policyholder and/or FDL. No notice to or consent by any Participant is necessary to amend or change the Plan.

AGENT

The Policyholder is not the agent of FDL.

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

You are receiving this notice because You have recently become covered under Your Employer's group health **plan** (the Plan). This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to You and to other members of Your family who are covered under the Plan when You would otherwise lose Your group health coverage. Contact Your Employer to determine if You are eligible for COBRA continuation coverage.

This notice generally explains:

- COBRA continuation coverage,
- When it may become available to You and Your family, and
- What You need to do to protect the right to receive it.

This notice gives only a summary of Your COBRA continuation coverage rights. For more information about Your rights and obligations under the Plan and under federal law, You should either contact the Plan Administrator or review the Certificate or Certificate of Coverage provided to You by Your Plan.

The Plan Administrator of the Plan is named by the Employer or by the group health plan. Either the Plan Administrator or a third party named by the Plan Administrator is responsible for administering COBRA continuation coverage. Contact Your Plan Administrator for the name, address, and telephone number of the party responsible for administering Your COBRA continuation coverage.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and Dependent children of employees may be qualified beneficiaries. Under the Plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact Your Employer and/or COBRA Administrator for specific information for Your Plan.

If You are an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from Your spouse.

Your Dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a "Dependent child."

If the Plan provides health care coverage to retired employees, the following applies:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and Dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

The Employer must notify the Plan Administrator within 30 days when the qualifying event is:

- The end of employment;
- The reduction of hours of employment;
- The death of the employee;
- In the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- The enrollment of the employee in Medicare (Part A, Part B, or both).

For the other qualifying events (divorce or legal separation of the employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), You must notify the Plan Administrator. The Plan requires You to notify the Plan Administrator within 60 days after the qualifying event occurs. Contact Your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage ***may*** last for up to 36 months when the qualifying event is:

- The death of the employee;
- The enrollment of the employee in Medicare (Part A, Part B, or both);
- Your divorce or legal separation; or
- A Dependent child losing eligibility as a Dependent child.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation can be extended.

Disability extension of 18-month period of continuation coverage

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and You notify the Plan Administrator in a timely fashion, You and Your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that Your Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Contact Your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second qualifying event extension of 18-month period of continuation coverage

If Your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and Dependent children in Your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and Dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child.

In all of these cases, You must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. Contact Your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

IF YOU HAVE QUESTIONS

If You have questions about Your COBRA continuation coverage, You should contact the Plan Administrator or You may contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone number of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members You should also keep a copy, for Your records, of any notices You send to Your Plan Administrator.

Fort Dearborn Life Insurance Company

Chicago, Illinois

Important Information Regarding Your Insurance

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of the insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number:

Fort Dearborn Life Insurance Company

1020 31st Street

Downers Grove, IL 60515

800 348-4512

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Commonwealth of Virginia

State Corporation Commission

Bureau of Insurance

Consumer Complaints/Inquiries

P.O. Box 1157

(800) 552-7945 (in-state)

(800) 371-9691 (out-of-state)

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Products and services marketed under the Dearborn National™ brand and the star logo are underwritten and/or provided by Fort Dearborn Life Insurance Company® (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands and Guam.

Administrative Office:

1020 31st Street • Downers Grove, Illinois 60515-5591

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