Nationwide Life Insurance Company

Home Office: One Nationwide Plaza, Columbus, Ohio

CERTIFICATE OF COVERAGE
ASSOCIATION DENTAL PLAN

INSURING AGREEMENT

The Nationwide Life Insurance Company has issued a Policy covering certain Eligible Classes of the Policyholder.

The Benefits of the Policy are described in this Certificate and Your Schedule of Benefits.

Final interpretation is governed by the Policy. You may review the Policy at the Policyholder's address during normal business hours. This Certificate replaces any and all Certificates previously issued for the Eligible Classes under the Policy. This Certificate describes the Policy in detail.

NOTICE CONCERNING YOUR CERTIFICATE

The Benefits and provisions of the Policy are described in this Certificate.

Please read Your Certificate carefully. Keep it in a safe place.

IMPORTANT NOTICE: Benefits are payable only for listed Covered Procedures that were both started and completed while the patient is insured under the Policy, and after any applicable Benefit Waiting Periods have been served.

The Policy under which the Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Person who Claims rights or Benefits under the Policy.

30 Day Right to Examine Certificate: There is a 30 day right to review this Certificate. If You decide not to keep it, it may be returned to the Policyholder, its agent or to Us within 30 days of the original Certificate Effective Date. In that event, We will consider it void from the Certificate Effective Date and refund all Premium paid. Any Claims paid during the initial 30 day period will be deducted from the refund.

Signed for Nationwide Life Insurance Company

President

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GENERAL DEFINITIONS

Accredited: The school, college or university has been evaluated and awarded accreditation by an accrediting agency that is recognized by the U.S. Department of Education or the Council on Higher Education Accreditation (CHEA) in Washington, DC.

Benefit: The dollar amount payable by Us to a Claimant or assignee under the Policy.

Benefit Waiting Period: The period of time starting on a Covered Person's Effective Date before Benefits for certain Services become payable. The Benefit Waiting Period is shown in the Schedule of Covered Procedures in the Schedule of Benefits.

Calendar Year: For the first year is the period of time that begins on the Effective Date and ends on December 31st or subsequent years, it is the period of time that begins on January 1st and ends December 31st.

Certificate: This document that provides a description of the Coverage available under the Policy.

Child or Children: See definition of Eligible Dependent.

Claim: A request for payment of covered Benefits.

Claimant: A person who has filed a Claim for Benefits under the Policy, as an Insured Person or as the dependent of an Insured Person.

Company: Nationwide Life Insurance Company. Also hereinafter referred to as We, Us and Our.

Coverage: The right of the Covered Person to receive Benefits subject to the terms, conditions, limitations and exclusions of the Policy.

Covered Expense: The lesser of:
1. the actual dental charge; or
2. the Maximum Reimbursement for a Covered Procedure.

Covered Dependent: Your Eligible Dependent who is insured under the Policy.

Covered Person: You and Your Eligible Dependents whom You have enrolled for insurance and paid any Premium due under the Policy.

Customary Maximum Allowable Charge (CMAC): A CMAC is used if a Provider who is a Non-Participating Provider performs a Covered Procedure. The amount of the CMAC is equal to the lesser of:
1. the actual dental charge; or
2. the customary charge for the dental Service.

We determine the customary charge from within the range of charges made for the same Service by other providers of similar training or experience in that general geographic area.

Deductible: The amount of Covered Expense that must be paid in full by You each Plan Year (or lifetime, when applicable) for each Covered Person (or to the maximum per family limit, when applicable) who incurs expenses for a Covered Procedure before any Benefits are payable by Us.

Dental Hygienist: Someone who is licensed to practice dental hygiene and is acting under supervision and direction of a Dentist, if required, and within the scope of his or her license.

Dentist: Any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render dental Services, perform dental surgery, or administer anesthetics for dental surgery.

Denturist: A person who is licensed to make fit, and repair artificial dentures and is operating under the scope of his or her license.

Domestic Partner: An individual in a relationship with You that satisfies the following criteria:

1. For at least six consecutive months prior to Your Domestic Partner's Effective Date of Insurance, You and Your Domestic Partner, are and have been each other's sole Domestic Partner and have maintained the same principal place of residence; and
2. Your Domestic Partner is at least 18 years of age; and
3. You and Your Domestic Partner are not married or related by blood; and
4. You and Your Domestic Partner are jointly responsible for each other's welfare and financial obligations; and
5. You and Your Domestic Partner are not legally married to anyone else.

Effective Date: The date on which insurance Coverage begins under the Policy.

Eligible Class: A group of people who are eligible for Coverage under the Policy. Each person of the Eligible Class will qualify for insurance on the date he or she completes the required Eligibility Waiting Period, if any.

Eligible Dependent: Includes:
1. Your Spouse (if not legally separated or divorced from You);
2. unwed Child from the moment of birth, until the Child attains Age 19; and
3. unwed Child who is a student may be covered until Age 26 provided such Child is a Full-Time Student and more than 50% dependent on You for support and maintenance and proof of the Child's enrollment as a Full-Time Student must be submitted to Us.

Children include natural children, stepchildren, adopted children, children Placed for Adoption, children appointed to Your custody by a court order, or foster children who are dependent upon You for support. Adopted children include a child where an Eligible Person has the assumption and retention of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. Such child is no longer considered an Eligible Dependent upon the termination of that legal obligation.

The term Eligible Dependent does not include any person who:
1. is in full-time active duty in the armed forces of any country or international authority; or
2. lives outside of the United States; or
3. is an Insured Person under the Policy.

Eligible Person: A person who belongs to an Eligible Class as described in the Schedule of Benefits.

Eligibility Waiting Period: The continuous length of time a Covered Person must serve in an Eligible Class to reach his or her eligibility date and begin his or her Coverage and Your Eligible Dependent Coverage. The Eligibility Waiting Period is shown in the Schedule of Benefits.

Enrollment Form: The document completed by You in electing Coverage under the Policyholder's Policy.

Family Member: A person who is related to the Covered Person in any of the following ways: Spouse, brother-in-law, sister-in-law, daughter-in-law, son-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or Child (includes legally adopted, step or foster child). A Family Member includes an individual who normally lives in the Covered Person's household.

Full-Time Student: A student who is enrolled in an Accredited educational institution or licensed trade school and considered full time according to the institution or school that he or she is attending.

Group: A Policyholder or entity who has entered into a contract with Us to provide Coverage under the Policy.

In-Network Benefits: Dental Benefits provided under this Certificate for Covered Procedures that are provided by a Participating Provider.

Insured Person: A person who is an Eligible Person, who has qualified for insurance by completing the Eligibility Waiting Period, and for whom insurance under the Policy has become effective.

Natural Tooth: Any tooth or part of a tooth that is:

1. organic and formed by the natural development of the body (i.e. not manufactured). Organic portions of a tooth include the clinical crown, enamel, dentin, cementum, root, and the enclosed pulp (nerve); and
2. performing its normal role in the mastication (i.e., chewing) process in the Covered Person's upper or lower arch and which is opposed in the Covered Person's other arch by another Natural Tooth or prosthetic (i.e., artificial) replacement. Third Molars are not considered Natural Teeth for purposes of the Policy.

Non-Participating Provider: A Provider who is not a Participating Provider. These Providers have not entered into an agreement with Us to limit their charges.

Out-of–Network Benefits: Dental Benefits provided under this Certificate for Covered Procedures that are not provided by a Participating Provider.

Participating Provider: A Provider who has been selected by Us for inclusion in the Participating Provider Program. These Participating Providers agree to accept Our Participating Provider Maximum Allowed Charges as payment in full for Services rendered. When dental care is given by Participating Providers, the Covered Person will generally incur less out-of-pocket cost for Services rendered.

Participating Provider Maximum Allowable Charge (MAC): The MAC is used if a Provider who is a Participating Provider performs a Covered Procedure. This is the amount that the Provider has agreed with Us to accept as payment in full for a dental Service. The MAC may also be used for Non-Participating Providers.

Participating Provider Program: Our program to offer a Covered Person the opportunity to receive dental care from Providers who are designated by Us as Participating Providers.

Participating Provider Program Directory: A list that is periodically updated and consists of selected Providers who:

1. are located in Your area; and
2. have been selected by Us to be Participating Providers and part of the Participating Provider Program.

Placement for Adoption; Placed for Adoption: A Child is placed in Your physical custody for the purpose of adoption.

Plan Year: The period of time shown in the Schedule of Benefits as Calendar Year.

Policy: The agreement between Us and the Policyholder which states the terms, conditions, limitations, and the exclusions regarding Coverage.

Policy Anniversary: The month and day as shown in the Policy as the Policy Anniversary.

Policyholder: The organization named in the Schedule of Benefits who has contracted with Us to provide benefits to You.

Premium: The periodic fee required to maintain Coverage for each Eligible Person and Dependent in accordance with the terms of the Policy.

Provider: A Dentist, Dental Hygienist, or a Denturist as defined in this section. Provider does not include a Family Member.

Reservist: A member of a reserve component of the Armed Forces of the United States. Reservist also includes a member of the Army National Guard and the Air National Guard.

Schedule of Benefits: This document shows You the amount of Benefits provided under the Policy.

Service: A procedure or supply which is performed by a Provider in connection with the dental care of a Covered Person. It is required and appropriate for treatment of the Covered Person's dental condition according to broadly accepted standards of dental care as determined by Us or Our dental consultants.

Sign or Signed: The use by a person of a symbol or method with the present intention to authenticate a record. Such authentication may be executed and/or transmitted by paper or electronic media, provided it is acceptable to Us and consistent with applicable law.

Sound Natural Tooth: A Natural Tooth which is fully restored to function, does not have any decay, is not more susceptible to injury than a virgin tooth, and is without periodontal disease.

Spouse: Your lawful Spouse who is an Eligible Dependent. The term also includes a Domestic Partner or civil union partner who is an Eligible Dependent, where allowed by law.

We, Us, Our, and **Insurer:** Means Nationwide Life Insurance Company.

Written or Writing: A record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

You and **Your:** Refers to an Insured Person.

Other terms are defined elsewhere under the Certificate.

COVERED PERSONS PREMIUMS

When are Your Premiums due?

The first Premium for each Covered Person is due on the date he or she enrolls for insurance under the Group Policy. Each Premium after the initial Premium is due at the end of the period for which his or her preceding Premium was paid.

What happens if You are late with a Premium payment?

A Grace Period of 31 days from the Premium due date is allowed for each Covered Person for payment of each Premium due after the initial Premium. The Covered Person's insurance will be continued during the Grace Period. If the Covered Person incurs a covered loss during the Grace Period, You will be liable to Us for payment of any Premium accruing during the period We continued his or her Coverage under this provision.

The Grace Period will not continue Coverage beyond a date as described in the "**When will Your Coverage end?"** provision.

WHEN COVERAGE BEGINS AND ENDS

Who is eligible?

Eligible Person: An individual is eligible for Coverage if he or she is in an Eligible Class as described in the Schedule of Benefits and if he or she satisfies any Eligibility Waiting Period as defined by the Policyholder.

Eligible Dependent: Your Eligible Dependents are also eligible for Coverage, provided that You are insured under the Policy and that Dependent Coverage is provided under the Policy.

Dual Eligibility Status: If both an Eligible Person and his or her Spouse are in an Eligible Class of the Policyholder, each may enroll individually or as a Dependent of the other, but not as both. Any Eligible Dependent Child may also only be enrolled by one parent/guardian. If the Spouse carrying dependent Coverage ceases to be eligible, please notify Us immediately. Dependent Coverage then becomes effective under the other Spouse's Coverage.

When do You enroll?

Enrollment is when an Eligible Person completes an Enrollment Form giving the information We require. As the Eligible Person, if You are required to pay all or part of the Premium for Coverage, You must agree to make the required contributions and pay the first Premium at time of enrollment. The enrollment for Coverage may be written or electronic on an Enrollment Form furnished or approved by Us.

Eligible Person: An Eligible Person who has met all eligibility requirements of the Policyholder may enroll at any time throughout the Plan Year. The Enrollment Form must be completed and Signed on or before the desired Effective Date of Coverage.

Eligible Dependent: If the Policy provides for Dependent Coverage, an Eligible Person may request enrollment of his or her Dependents at the time he or she requests enrollment for himself per the above. If You acquire a new Dependent, as an Insured Person, You may request enrollment.

Newborn and Adopted Children/Children Placed for Adoption: Your newborn or adopted child will be covered for the first 31 days following their birth, adoption, or Placement for Adoption. To continue Coverage beyond that 31-day period, You must enroll the Child at any time during the 31-day period. Any required Premium must be paid when due from the date of birth, adoption, or Placement for Adoption. Otherwise, Coverage for that Child will terminate as soon as the 31-day period expires.

When will Your Coverage begin?

If the Policyholder requires You to contribute toward the cost of all or part of the insurance, such insurance will not become effective for You before the first Premium is paid.

Subject to Your enrollment, You will become insured under the Policy at 12:01 a.m. at the main office of the Policyholder on Your first day of Coverage.

When will Coverage begin for Your Dependents?

Subject to the enrollment procedure described above and payment of the Premium due, Your Dependents will become insured on the same date and at the same time as You. If You acquire additional Dependents after Your Effective Date of Coverage and have Dependent Coverage, and provided You enroll Your Eligible Dependents as indicated above, the Effective Date of the newly acquired Dependents will be the first of the month following the date You complete and Sign the Enrollment Form requesting Coverage, subject to timely payment of any Premium due. If You acquire additional Dependents after Your Effective Date of Coverage and do not have Dependent Coverage, and provided You enroll Your newly Eligible Dependents as indicated above, the Effective Date will be, for all Eligible Dependents, the date You enroll such Dependent; subject to payment of any Premium due. If Your Dependent is enrolled as a result of a court or administrative order, Coverage for such child shall take effect on the first of the month following the date of enrollment, if We are notified in accordance with Our enrollment guidelines and once the required Premium, if any, has been paid.

When will Benefits and/or rates change?

Change in Eligible Class or Location: The amount or cost of Your Benefit and/or Benefits for Your Covered Dependents may change if You become insured under a different Eligible Class or You move.

The change takes effect on the first day of the Policy month following the date the change occurs.

When will Your Coverage end?

All of Your insurance under the Policy will terminate at 12:01 a.m. at the main office of the Policyholder on the earliest of the following dates:

1. The date the Policy terminates;
2. The date You cease to be an Eligible Person;
3. The date specified by Us in written notice to You that Your Coverage ends due to fraud or misrepresentation;
4. The date We receive written notice from You or the Policyholder telling Us to terminate Coverage of a Covered Person or the date requested in that notice, whichever is later;
5. The last day of the period for which Premium was paid, if a Premium is not paid when due;
6. The date the Policy is changed to end the insurance for Your Eligible Class;
7. The date You enter full-time active duty in the armed forces of any country or international authority;
8. The date of Your death.

When will Coverage end for Your Dependent?

Your Dependent's insurance under the Policy will terminate at 12:01 a.m. at the main office of the Policyholder on the earliest of the following dates:

1. The date the Policy terminates;
2. The date the Dependent ceases to be an Eligible Dependent;
3. The date in which You cease to be insured under the Policy, unless Benefits are extended under the "**Will Benefits be extended beyond the termination date for any reason?**" provision noted below;
4. The date You cease to be in an Eligible Class for Dependent Coverage;
5. The last day of the period for which Premium was paid, if a Premium is not paid when due;
6. The date We receive written notice from You or the Policyholder telling Us to terminate Coverage on any Dependent or the date requested in that notice, whichever is later;
7. The date the Policy is changed to end the insurance for Your Eligible Class;
8. The date that the Dependent enters full-time active duty in the armed forces of any country or international authority;
9. The date of Your death, unless Benefits are extended under the "**Will Benefits be extended beyond the termination date for any reason?**" provision noted below.

Handicapped Dependent Children: Insurance will continue for a handicapped Child who has attained limiting age as shown in the definition of Eligible Dependent, if such Child is unwed and mentally or physically incapable of earning their own living; and dependent on You for support and maintenance and was covered on the day immediately prior to attaining the limiting age. Proof of incapacity must be furnished to Us within 31 days of attainment of the limiting age.

Notice Required When Your Coverage Terminates: We must be informed within 31 days of the date Your Coverage terminates for any reason. Failure to provide timely notice will not continue Your insurance past the time it would have otherwise ended as provided above. In the event Premiums have been paid to Us on Your behalf after Your Coverage should have terminated, We will refund the Premium for the period for which Premiums were paid in error up to a maximum of 1 Policy month. If We are not notified that Your Coverage is terminated and We pay any Benefits for Your Covered Expenses incurred after the date Your Coverage terminated, the full amount of those Benefits will be considered an overpayment which must be repaid to Us or You will be responsible for payment of all Premiums due through the Policy month in which Benefits were paid.

Will Benefits be extended beyond the termination date for any reason?

If Your insurance ends while a Covered Person is in the process of having dental work completed under this Policy, there will be an additional 30 days for completion if:

1. the dental expense is incurred while insured under this benefit; and
2. the dental procedure is completed within 30 days after Coverage terminates.

What happens if You return to eligible status?

After loss of eligibility: If You meet the definition of Eligible Person You may re-enroll for insurance under this Policy.

COVERAGE PROVISIONS

What Benefits are provided to Covered Persons?

Upon receipt of Proof of Loss that a Covered Person has incurred a Covered Procedure as shown in the Schedule of Covered Procedures, We will determine if Benefits are payable.

Before We determine Benefits, the Covered Person must satisfy any Benefit Waiting Periods and the Deductible, if applicable. We then pay the Percentage of Covered Expense, subject to the Plan Year Benefit Maximum, for Covered Procedures. The Covered Procedure must be for:

1. necessary dental treatments to a Covered Person while his or her Coverage under the Policy is in force; and
2. treatment, which in Our opinion has a reasonably favorable prognosis for the patient.

The procedure must be performed by a Provider.

Additionally, the benefit payable is subject to the following:

1. The Covered Procedure must start and be completed while the Covered Person's Coverage is in force.
2. Each Covered Procedure may be subject to specific Frequency Limitations, as shown on the Schedule of Covered Procedures.
3. Other limitations and Exclusions that may affect Coverage are shown in the "**Exclusions**" section of this Certificate.

A Covered Person may choose a Provider of his or her choice, and may choose the Services of a Provider who is either a Participating Provider or a Non-Participating Provider. Benefits under this Certificate are determined and payable in either case. If a Participating Provider is chosen, the Covered Person will generally incur less out-of-pocket cost unless the Policyholder has selected an In-Network only plan.

How does a Deductible affect a Covered Person's Benefits?

The Deductible is applied chronologically according to the dates on which the Covered Procedures on a Claim were processed by Us. The amount of the Deductible is shown in the Deductible section of the Schedule of Benefits.

How does a Benefit Waiting Period affect a Covered Person's Benefits?

If a Covered Procedure is started before the Benefit Waiting Period for that procedure ends, that procedure is not covered under the Policy. If a Covered Person's Coverage under the Policy ends and then the Person later becomes insured again, that Covered Person's Effective Date is the most recent Effective Date unless stated otherwise in the Policy. The Benefit Waiting Periods for Covered Procedures are listed in the Schedule of Covered Procedures.

If Benefits are not paid at 100%, how does the Percentage of Covered Expense affect Benefits?

The Percentage of Covered Expense is the percentage of the Covered Expense that We will pay for a Covered Procedure. The percentage applicable to a Covered Person may vary by Covered Procedure and the length of time the Covered Person has been continuously covered for dental insurance. The Percentage of Covered Expense for a Covered Procedure is shown in the Schedule of Benefits.

How are Covered Expenses determined?

The Covered Expense is based on the Maximum Reimbursement for Your plan. For Your plan, the Maximum Reimbursement is based on MAC or CMAC and is shown in the Schedule of Benefits.

Is there a Plan Year Maximum Benefit?

The Plan Year Benefit Maximum is the maximum benefit payable by the Policy for all Covered Procedures completed in a Plan Year. This maximum will apply even if a Covered Person's Coverage is interrupted or if a Covered Person has been covered both as an Insured Person and as a Covered Dependent during a Plan Year. The Plan Year Benefit Maximum is listed in the Schedule of Benefits.

For purposes of Benefit payments, when does a procedure start?

For benefit determination purposes, the following will define the date on which certain Covered Procedures will be deemed started on the date the Service is performed.

For purposes of Benefit payments, when is a procedure completed?

For benefit determination purposes, the following will define the date on which certain Covered Procedures will be deemed completed on the date the procedure is started.

Are alternative Benefits acceptable or required?

There is often more than one Service that can be used to treat a dental problem or disease. In determining the Benefits payable on a Claim, different materials and methods of treatment will be considered. The amount payable will be limited to the Covered Expense for the least costly Service, which meets broadly accepted standards of dental care as determined by Us. The Covered Person and his or her Provider may decide on a more costly procedure or material than We have determined to be satisfactory for the treatment of the condition. We will pay a benefit toward the cost of the more expensive procedure or material, but payment will be limited to the Benefits Payable for Covered Expenses for the least costly Service. We will not pay the excess amount.

CLAIM PROVISIONS

Submitting Claims and Receiving Reimbursement

How to submit a Claim: The Claimant or You may use standard American Dental Association (ADA) approved Claim forms supplied by Your Provider or You may request forms from Us. Upon receipt by Us of the request for claims forms, We will send Claim forms to the Claimant or You. If such forms are not sent to You or the Claimant within 15 days, You or the Claimant will meet the Proof of Loss requirements below if We are given written proof of the nature and extent of the loss including the treatment performed in terms of the ADA Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request x-rays, narratives and other diagnostic information, as We see fit, to determine Benefits.

When to submit a Claim: Proof of Loss must be provided within 90 days from the date of loss to file written Proof of Loss. We will not deny or reduce any Claim filed after 90 days from the date of loss if:

1. it was not reasonably possible to file the Claim within that 90-day period; and
2. the Claim is filed as soon as it is reasonably possible.

In any event, Proof of Loss must be given to Us within one (1) year after it is due, unless You are legally incapable of doing so.

What if additional information is required? If the Proof of Loss provided does not contain all necessary information or is not on an appropriate Claim Form, forms for filing Proof of Loss will be sent to the Claimant along with a request for the missing information.

When will the Claim be paid or denied? After receiving written Proof of Loss and Premium payment, We will pay or deny all Benefits then due for dental Claims directly to You or Your Provider. We will pay or deny all Claims or any portion of any Claims within 30 days, or as required by Your state, after receipt of the Claim. If a Claim or a portion of a Claim is contested by Us, You shall be notified in Writing, that the Claim is contested or denied, within 30 days after receipt of the Claim by Us. The notice that a Claim is contested shall identify the contested portion of the Claim and the reasons for contesting the Claim. Upon receipt of the additional information requested from You, We shall pay or deny the contested Claim or portion of the contested Claim, within 60 days. We shall not pay or deny any Claim later than 120 days after receiving the Claim. We will, upon request, provide to You an estimate of the amount We will pay for a particular dental Service.

All payments made to or by Us will be made in United States dollars.

What if there is an overpayment of Benefits? We reserve the right to deduct from any Benefits properly payable under this Policy the amount of any payment that has been made:

1. in error; or
2. pursuant to a misstatement contained in a Proof of Loss; or
3 pursuant to fraud or misrepresentation made to obtain coverage under this Policy within two (2) years after the date such Coverage commences; or
4. with respect to an ineligible person; or
5. pursuant to a Claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future Claim for Benefits under the Policy made by an Insured Person if Claim payments previously were made with respect to an Insured Person.

Coordination of Benefits (COB)

What if a Covered Person has more than one plan covering similar procedures? When a Covered Person has dental coverage under more than one Plan, as defined below, the benefits payable between the Plans will be coordinated.

Benefit Coordination: Benefits will be adjusted so that the total payment under all Plans is no more than 100 percent of the Insured's Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of COB.

If a Covered Person's Benefits paid under this Plan are reduced due to COB, each benefit will be reduced proportionately. Only the amount of any benefit actually paid will be charged against any applicable Plan Year Benefit Maximum.

Order of Benefit Determination:

1. When this is the Primary Plan, We will pay Benefits as if there were no other Plans.
2. When a person is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.
3. When a person is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:
   a. Non-Dependent/Dependent. A Plan that covers a person other than as a Dependent will pay before a Plan that covers that person as a Dependent.
   b. Dependent Child/Parents Not Separated or Divorced. For a Dependent Child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the Dependent Child for the longer period will pay first.
   c. Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the Child are determined in the following order:
      i. The Plan of the parent who has responsibility for providing insurance as determined by a court order;
      ii. The Plan of the parent with custody of the Child;
      iii. The Plan of the spouse of the parent with custody; and
      iv. The Plan of the parent without custody of the Child.
   d. Dependent Child/Joint Custody: If the joint custody court decree does not specifically state which parent is responsible for the Child's medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.
   e. Active/Inactive Employee. The Plan which covers the person as an employee who is neither laid off nor retired (or as that employee's Dependent) is Primary over the Plan which covers that person as a laid off or retired employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.
   f. Longer/Shorter Length of Coverage. When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

*Right to Receive and Release Needed Information: W*e may release to, or obtain from, any other insurance company, organization or person information necessary for COB. This will not require the consent of, or notice to You or any Claimant. You are required to give Us information necessary for COB.

Right to Make Payments To Another Plan: COB may result in payments made by another Plan that should have been made by Us. We have the right to pay such other Plan all amounts it paid which would otherwise have been paid by Us. Amounts so paid will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

Right to Recovery: COB may result in overpayments by Us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.

Definitions Related to Coordination of Benefits

Allowable Expense: An expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.

Coordination of Benefits: Taking other Plans into account when We pay benefits.

Plan: Any plan, including this one that provides benefits or services for dental expenses on either a group or individual basis. "Plan" includes group and blanket insurance and self-insured and prepaid plans. It includes government plans, plans required or provided by statute (except Medicaid), and no fault insurance (when allowed by law). "Plan" shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or services of other plans and that part which does not.

Primary Plan: The Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Plans.

Year: The Plan Year, or any part of it, during which a person claiming benefits is covered under this Plan.

COMPLAINT AND APPEAL PROCEDURES

What if You have questions about your Benefits or Claim payments?

If You have any questions about Your Benefits, a specific Claim payment, or denial, You should contact Us in Writing or by telephone within 30 days.

What if You don't agree with a Claim denial?

If We send You a written statement denying Your Claim in whole or in part, You may submit a written appeal to Us that outlines Your concerns and Your efforts to resolve the matter. The appeal must be filed within 60 days of the receipt of denial. A written decision with respect to the appeal shall be sent to You within 60 days after its receipt, unless special circumstances exist which require additional time, in which case a written decision with respect to the appeal will be sent to You as soon as possible.

Please send to:
Nationwide Multiflex Dental Plans
P. O. Box 2947
2100 Covington Centre
Covington, LA 70434-2947

If You are not satisfied by the appeal response or for any reason, You may write to the State Department of Insurance. Describe the circumstances and Your complaint.

EXCLUSIONS

No Benefits are payable under the Policy for the Services listed below. In addition, the Services listed below will not be recognized toward the satisfaction of any Deductible:

1. Any Services which are not included in the Schedule of Covered Procedures;
2. Any Service started or appliance installed before the Effective Date or after the Termination Date, except in those instances noted in this Certificate;
3. Any procedure We determine is not necessary, does not offer a favorable prognosis, does not have uniform professional endorsement or is experimental in nature;
4. Any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations unless such procedure is listed in the Schedule of Covered Procedures;
5. Appliances, Services or procedures relating to:
   a. the change or maintenance of vertical dimension;
   b. restoration of occlusion (unless otherwise noted in the Schedule of Covered Procedures—only for occlusal guards);
   c. splinting;
   d. correction of attrition, abrasion, erosion or abfraction;
   e. bite registration; or
   f. bite analysis;
6. For Orthodontia Services;
7. Services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain unless such procedure is listed as a Covered Procedure in the Schedule of Covered Procedures;
8. Charges for implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized Services or attachments unless such procedures are listed as Covered Procedures in the Schedule of Covered Procedures;
9. Athletic mouth guards; myofunctional therapy; treatment for malignancies, cysts and neoplasms; failure to keep scheduled appointment; charges for completion of Claim forms, infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; charges for travel time; transportation costs; professional advice; treatment of jaw fractures; orthognathic surgery; exams required by a third party other than Us, personal supplies (e.g., water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
10. Prescription drugs, premedication, pharmaceuticals, or analgesia;
11. Dental disease, defect or injury caused by a declared or undeclared war or any act of war or terrorism or taking part in an insurrection or riot; the commission or attempted commission of a crime; an intentionally self-inflicted injury or attempted suicide while sane or insane;
12. Dental treatment not approved by the American Dental Association or which is clearly experimental in nature;
13. Any charge for a Service for which benefits are available under Worker's Compensation or an Occupational Disease Act or Law, even if You did not purchase the coverage that is available to You;
14. Any charge for a Service performed outside of the United States.
15 Local anesthetic, including light anesthetic, as a separate fee;
16. Dental care paid for, required, or provided by or under the laws of a national, state, local or provincial government, or treatment furnished within a hospital or other facility owned or operated by a national or state government unless the Insured Person has a legal obligation to pay;
17. Dental services performed in a hospital and related hospital fees;
18. Services covered under an existing medical plan;
19. The portion of an expense which is in excess of the Reasonable Charge;
20. Fees associated with a cancelled or missed appointment;
21. General anesthesia and I.V. sedation.

GENERAL PROVISIONS

Assignment
You may assign the Benefits of the Policy to the Provider rendering dental Service. You may not assign the Policy in any other way or to any other person. We must be notified in Writing of the assignment. The assignment will not be effective until We receive the Written notice. We assume no responsibility for the validity of any assignment.

Changes to Policy
The Policy may be amended at any time by written agreement between the Policyholder and Us, without the consent of or notice to any other individual. Any amendment to the Policy must be in Writing and be attached to it. The amendment must bear the signature or a reproduction of the signature of Our President, a Vice President, or Secretary.

Incontestability
We will not use misrepresentations made by You in a written application to contest the validity of the insurance with respect to which such statement was made, after such insurance has been in force prior to the contest for a period of two years during Your lifetime, unless the misrepresentations are fraudulent. This section does not prevent Us from using at any time a defense based on:

1. non-payment of Premium; or
2. any other provision of the Policy; or
3. any other defense that is allowed by law.

If You apply to add additional Covered Persons, the incontestable period with respect to newly added Covered Persons is for two years from such Covered Person's effective date. If You apply for increased Benefits under the Policy, We will not use misrepresentations made by You in a written application for such increase to contest the validity of the increased insurance with respect to which such statement was made, after such increase has been in force prior to the contest for a period of two years from the effective date of the increase.

Errors
You must be properly insured under the Policy. An error or omission by the Policyholder or by Us will not cause You to become Insured. An error or omission by the Policyholder or by Us will not cancel insurance that should continue nor continue insurance that should end. The requirements of the Policy must be properly met for any change in the amount of Your insurance to take effect. We have the right to full recovery of any overpayments made. Such reimbursement will be required regardless of whether the overpayment occurred due to an error by Us, or by You, or Your representative or beneficiary, or the Policyholder.

Legal Actions
No legal action may be brought against Us to recover Policy Benefits until at least 60 days after the required written Notice of Loss is submitted to Us. No such action may be brought more than 3 years after the time written Proof of Loss is required by the Policy to be given.

Misrepresentation
Any statement You make in an application to become insured is a representation and not a warranty. No representation made by You in an application to become insured will be used to reduce or deny Your Claim or contest the validity of Your insurance unless:

1. Your insurance would not have been approved except for Your misrepresentation; and
2. Your misrepresentation is contained in a written instrument Signed by You; and
3. We give You or Your representative a copy of the written instrument that contains Your misrepresentation.

Misstatement of Age or Fact
If a Covered Person's age or any other fact was misstated, We will use the correct facts to determine whether he or she is insured and if so, for what amount and duration. We will adjust Premium rates to the Covered Person's correct age. We may make this change back to the date Coverage became effective based on the misstated information.

Notice to Policyholder
Written notice given by Us to an authorized representative of the Policyholder shall be deemed notice to all affected Covered Persons in the administration of the Policy, including termination of the Policy and termination of individual Coverage under the Policy.

Workers' Compensation Not Affected
The Policy does not replace or change any requirement for coverage under workers' compensation insurance.