GROUP DENTAL INSURANCE CERTIFICATE

Underwritten by:
AXIS INSURANCE COMPANY
(A Stock Company)

Administrative Office:
10000 Avalon Blvd., Suite 200
Alpharetta, GA 30009

Home Office:
233 South Wacker Drive, Suite 4930
Chicago, IL 60606

CERTIFICATE OF INSURANCE

AXIS Insurance Company (the "Company") certifies that certain Eligible Persons are Insured Persons for the benefits described in this Certificate. This insurance is subject to the eligibility and effective date requirements described in the ELIGIBILITY section of this Certificate.

DATE YOUR INSURANCE TAKES EFFECT

Your insurance will take effect on the Coverage Effective Date shown in the *Schedule of Benefits*. You must be in Active Service and in an Eligible Class on this date. If You are not in Active Service, Your insurance will take effect on the day You resume such work.

The date insurance is to take effect might not be a scheduled workday. If so, You will be considered in Active Service on such date if You were in Active Service on Your last scheduled workday. You are considered in Active Service:

- during Your normal vacation time provided by Your Employer;
- during jury duty;
- on any holiday, or day of the weekend; or
- on any day of an excused leave approved by Your Employer.

IMPORTANT NOTICE

This Certificate is a summary of the group policy (the "Policy") provisions that affect Your insurance. It is merely evidence of the insurance provided by such policy for LCS Community Employment, LLC (the "Po licyholder").

The Policy is a contract between the Company and the Policyholder. It may be changed or ended without notice to or consent of any Insured Person. The benefits described in this Certificate are provided by Policy number TGDT04600792. The Company is providing this electronic version of the Certificate at the request of the Policyholder. The Policyholder maintains the Policy, which includes a copy of the Certificate. The Policy is available for You to review and copy. If there is any conflict between the information in this electronic version of the Certificate and the Policy, the Policy will control in all respects.

RIGHT TO EXAMINE CERTIFICATE. For coverage that requires a contribution from the Insured Person, the Certificate issued to each Insured Person can be returned for any reason within 30 days after it is received by the Insured Person. The Certificate should be returned by mail or in person to the Company. Any premium paid will be refunded and the Certificate will be treated as if it were never issued.

The President and Secretary of AXIS Insurance Company witness this Certificate.

Secretary

President

THIS IS LIMITED BENEFIT COVERAGE.
PLEASE READ THIS CERTIFICATE CAREFULLY.
Non-Participating

CERTIFICATE INDEX

SCHEDULE OF BENEFITS

This Certificate is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, PLEASE READ ALL OF THE CERTIFICATE PROVISIONS CAREFULLY.

The *Schedule of Benefits* provides a brief outline of the coverage and benefits provided by the Policy. Please read the Description of Benefits sections for full details.

ELIGIBLE CLASSES	A person may not be an Insured Dependent and a Primary Insured Person at the same time. Class 1: All Part Time employees working 20-29.9 hours, who are in Active Service and selected dental coverage. The coverage may also include the Spouses and Dependent Children of the Employees if coverage for the Spouses and Dependent Children is selected.
Type of Coverage	Employee Employee plus one Employee plus Child(ren) Family Coverage
Coverage Effective Date	• January 1, 2026 for coverage under a Prior Plan • As set forth in the Eligibility provision for new enrollees
Policy Effective Date	January 1, 2026
Policy Anniversary Date	January 1, 2027
Policy Term	The time period from the Policy Effective Date to the Policy Anniversary Date, and each one year period thereafter until the Policy otherwise terminates
Eligibility Waiting Period	None

If an Insured Person is eligible under one Eligible Class and later becomes eligible under a different Eligible Class, changes in His insurance due to the class change will be effective on the date of the change in class.

There may be several plans available under the Policy. Not all plans may be available for selection for every individual. The Policyholder makes the determination of which plans are available to each group of individuals.

The company will pay benefits on the basis of the plan selected in the Application/Enrollment Form.

Your Dependents are eligible for coverage if coverage is elected in the Application/Enrollment Form.

Benefits are payable on a Plan Year basis. Coverage is limited by the specific benefit maximums shown below.

SCHEDULE OF BENEFITS

Class 1: The coverage is effective only if the Employee selected the Dental Plan on His enrollment.

Covered Services	Benefit Waiting Period	Indemnity Benefit Amount	Indemnity Benefit Amount
Deductible		None	None
Individual		None	None
Family		None	None
Pre Treatment Review		$300	$300
Maximum Plan Year Limit for Types 1 through 7		$500 per Plan Year per Insured Person	$1,000 per Plan Year per Insured Person
Type 1 – Preventive & Diagnostic	None		
Oral Exams, including prophylaxis		$36	$72
Bitewings, per film		$5	$10
X-ray, panoramic or cephalometric		$36	$72
Sealants/topical fluoride		$11	$22
Space Maintainers		$108	$216
Type 2 – Major Restorative	12 consecutive		
Crowns, Bridges & Dentures		$180	$360
Pre-fabricated Crowns		$60	$120
Crown Build-Up Procedures		$48	$96
Type 3 – Minor Restorative	None		
Fillings (Restorations)		$42	$84
Crowns, Bridges & Dentures		$24	$48
Relining or Rebasing Dentures		$60	$120
Type 4 – Endodontics	None		
Root Canals, Apicoectomies		$192	$384
Root Amputation		$96	$192
Therapeutic Pulpotomy, Retrograde Fillings, Apexification, Hemisection		$48	$96

Type 5 – Periodontics	12 consecutive months		
Annual Maximum for Periodontic Services		$250 per Insured Person	$500 per Insured Person
Tissue Grafts or Bone Surgery		$96	$192
Gingivectomy (per quadrant), Periodontal Splinting, Root Planing		$36	$72
Gingival Curettage (per quadrant)		$60	$120
Gingivectomy (per tooth)		$24	$48
Type 6 – Oral Surgery	12 consecutive months		
Surgeries Level 1		$120	$240
Surgeries Level 2		$66	$132
Surgeries Level 3		$36	$72
Type 7 – General Anesthesia and Intravenous Sedation	None	General Anesthesia	General Anesthesia
		First ½ hour: Add'l 1/4 hour: $72 Intravenous Sedation	First ½ hour: Add'l 1/4 hour: $144 Intravenous Sedation
Type 8 – Orthodontia	12 consecutive		
Orthodontia Services (per course of Treatment)		$250 per lifetime per Insured Person	$500 per lifetime per Insured Person

GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

Active Service/ Actively at Work means the Insured Person will be considered in Active Service with His Employer on any day that is either of the following:

1. one of the Employer's scheduled work days on which the Employee is performing His regular duties on a full-time basis, either at one of the Employer's usual places of business or at some other location to which the Employer's business requires the Employee to travel; or
2. a scheduled holiday, vacation day or period of Employer-approved paid leave of absence, other than sick leave, only if the Employee was in Active Service on the preceding scheduled workday.

Accident or Accidental means a specific event that occurs while the Insured Person is covered under this Policy.

Age means an Insured Person's age for purposes of premium calculations. It is His Age attained on the Coverage Effective Date for Him under this Certificate.

Annual Re-Enrollment means a period of time set by the Policyholder and the Company during which the Insured Person may apply, in writing, for coverage under the Policy, or change coverage if He is currently enrolled.

Benefit Waiting Period means a period of consecutive months for which no benefits are payable. The Benefit Waiting Period will be reduced to the extent the Insured Person was continuously insured under the corresponding benefit section of the Prior Plan.

Company means AXIS Insurance Company.

Contributory Plan means a plan for which the Insured Person pays a portion of the premium.

Course of Treatment means all treatment that result from an exam by a Dentist. The treatment must be recommended by such Dentist. A Course of Treatment will be considered to start on the date of the exam. It will end on the date all recommended services have been rendered.

Coverage Effective Date means the date referenced in the *Schedule of Benefits.*

Dependent Child means the Primary Insured Person's unmarried child who meets the following requirements.

1. a child from birth to 26 years old;
2. a child who is 26 or more years old but less than 30 years old, enrolled in a school as a full-time student and primarily supported by the Primary Insured Person. Coverage will continue during any period between school terms or school years as long as the Company is provided satisfactory proof that He has enrolled for the next following school term or year; or
3. a child who is 26 or more years old, primarily supported by the Primary Insured Person, and incapable of self-sustaining employment by reason of mental or physical handicap.

Proof of the child's condition and dependence must be submitted to the Company within 31 days after the date the child ceases to qualify as a Dependent Child for the reasons listed above. During the next two years, the Company may, from time to time, require proof of the continuation of such condition and dependence. After that, the Company may require proof no more than once a year.

A Dependent Child, for purposes of this definition, includes the Primary Insured Person's:

1. natural child;
2. adopted child, beginning with any waiting period pending finalization of the child's adoption;
3. stepchild who resides with the Primary Insured Person; and
4. child for whom the Primary Insured Person is legal guardian, as long as the child resides with the Primary Insured Person and depends on Him for financial support. Financial support means that the Primary Insured Person is eligible to claim the dependent for purposes of Federal and State income tax returns.

If the Primary Insured Person who is the legal guardian of a child is not a step-parent, grandparent, aunt or uncle, then the child must have resided with Him for at least six consecutive months and intends to reside with Him for an indefinite period of time.

Deductible means the amount that an Insured Person must incur each plan year before any benefits are paid by the Company. The Deductible is shown in the *Schedule of Benefits.* **Credit For Deductible** – For the Plan Year in which the Insured Person becomes insured, the Deductible will be reduced by the covered charges which were 1) Incurred while insured by the Prior Plan, and 2) used to satisfy the deductible for that plan for the same year.

Dentist means a person who is:

- Licensed to practice dentistry in the state where the dental procedure is performed; and
- Operating within the scope of his or her license; or
- Licensed or certified to perform dental procedures in the state where the dental procedure is performed.

The Dentist or licensed practitioner may not be the Insured Person, or an Immediate Family Member. The Dentist or licensed practitioner cannot reside with the Insured Person, or be retained by the Primary Insured Person's Employer.

Eligible Class means the classes listed in the *Schedule of Benefits*.

Eligibility Waiting Period means the period of time of continuous employment that the Primary Insured Person must satisfy before coverage under this Certificate is effective.

Employee means, for eligibility purposes, a person working for the Employer who is in an Eligible Class as shown in the *Schedule of Benefits*.

Employer means the Policyholder and any affiliates, subsidiaries or divisions covered under this Policy on its effective date, or a later date agreed to by the Company.

Family Coverage means coverage in force under the Policy on a Primary Insured Person's Spouse and/or Dependent Children:

1. that the Primary Insured Person has elected to cover under the Policy; and
2. for whom premium has been paid.

He, His, Him, You, Yours refers to any individual, male or female.

Hospital an institution that meets all of the following:

1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis; and
6. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics; or
3. a Veterans' Administration Hospital or Federal Government Hospital unless the Insured Person incurs an expense.

Immediate Family Member means a person who is related to the Insured Person in any of the following ways: Spouse, brother-in-law, sister-in-law, daughter-in-law, mother-in-law, father-in-law, parent, siblings (includes stepbrother or stepsister), grandparents, or child (includes legally adopted or stepchild).

Injury means damage to an Insured Person's mouth due to an Accident, and complications arising from that damage. Injury does not include damage to teeth, appliances or prosthetic devices which results from chewing or biting food or other substances.

Insured Person means a person in an Eligible Class, as defined in the *Schedule of Benefits,* for whom required premium has been paid when due and for whom coverage under this Certificate remains in force. May include Insured Spouse and/or Insured Dependent Child covered under this Certificate.

Insured Dependent means a Primary Insured Person's Dependent Child or a Primary Insured Person's Spouse, for whom premium is paid while covered under this Certificate.

Insured Dependent Child(ren) means the Primary Insured Person's Dependent Child for whom premium is paid while covered under the Certificate.

Insured Spouse means the Primary Insured Person's Spouse for whom premium is paid while covered under the Certificate.

Inpatient means confined overnight as a registered bed patient in a Hospital or other medical facility where at least one day's room and board is charged. The confinement must be on the advice of a Physician.

Medically Necessary means a Covered Service that:

1. is essential for diagnosis, treatment, care, service, supply or medicine which it is appropriate and essential for diagnosis and treatment of the Insured Person's symptoms, prescribed or performed;
2. meets generally accepted methods of dental treatment; and
3. is ordered by a Dentist or a Specialist and performed under His care, supervision or order.

The fact that a Dentist, Hospital, or other provider may prescribe, order, recommend, or approve a service or supply, does not, of itself, make it Medically Necessary or a Covered Service.

Plan Year means the time period for calculating certain maximum benefit amounts under the Policy. The Plan Year is typically 1 year (12 months). The initial Plan Year will begin on the Coverage Effective Date and may be less than 1 year (12 months). The Plan Year may also be reset on the Policy Anniversary Date causing plan years to be less than 1 year (12 months). Insured Dependents will have the same Plan Year as the Primary Insured Person.

Policy Effective Date means the date the Policy takes effect for the Policyholder.

Policyholder means the entity, named on the Policy's face page, to which the Company issues the Policy.

Primary Insured Person means a person in an Eligible Class as defined in the *Schedule of Benefits*, other than an Insured Spouse or Insured Dependent, for whom, an enrollment form has been accepted by the Company, required premium has been paid when due and for whom coverage under the Policy remains in force.

Prior Plan means a group insurance policy issued to the Policyholder and in force immediately prior to the Policy Effective Date, and which provided similar benefits to this Policy.

Sickness means an illness or disease which requires treatment by a Physician.

Schedule of Benefits means the *Schedule of Benefits* in this Certificate.

Specialist means a licensed Dentist who is board certified in one or more of the following specialties: Endodontics, Periodontics, Pediodontics, Prosthodontics, Oral Surgery, Orthodontics, and any other board certified specialty outside of general dentistry.

Spouse means the Primary Insured Person's lawful spouse.

Usual and Customary Charge(s) means the normal charge that:

1. is made for a Covered Service;
2. does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred; and
3. does not include charges that would not have been made if no insurance existed.

We, Us, Our means AXIS Insurance Company and its duly authorized agents.

You, Your means the person to whom this Certificate is issued.

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

Policy Effective Date
The Company agrees to provide the benefits described in this Certificate in consideration of the Policyholder's application and payment of the initial premium when due. Insurance coverage begins on the Policy Effective Date shown in the *Schedule of Benefits*.

Eligibility
A Primary Insured Person becomes eligible for insurance under this Certificate on the date He meets all of the requirements of one of the Eligible Classes and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits*. A Spouse and Dependent Children of an eligible Primary Insured Person become eligible for any dependent insurance provided by this Certificate on the later of the date the Primary Insured Person becomes eligible and the date the Spouse or Dependent Child meets the applicable definition shown in the General Definitions section of this Certificate. No person may be eligible for insurance under this Certificate as both a Primary Insured Person and a Spouse or Dependent Child at the same time.

No enrollment is required if a person is not required to contribute towards the cost of coverage. Such person's coverage will become effective on the latest of the following dates:

1. the Policy Effective Date;
2. the date the person becomes a member of an Eligible Class after the Eligibility Waiting Period has been met;
3. the date for which the first premium for the person's coverage is paid; and
4. the Coverage Effective Date shown in the *Schedule of Benefits*.

A person is required to enroll for coverage for which He is required to contribute towards the cost of coverage. Such person's coverage will become effective on the latest of the following dates:

1. the date the person's enrollment form is received by the Company, provided such person has satisfied any required Eligibility Waiting Period, if such date is within 31 days of the date He becomes a member of an Eligible Class;
2. the date for which the first premium for the person's coverage is paid;
3. the Coverage Effective Date shown in the *Schedule of Benefits*, provided premium for such person is paid; and
4. the Policy Effective Date.

Requirements for insuring Spouse or Dependent Child(ren) on Contributory Plans
A Primary Insured Person must request insurance in writing for each Spouse or Dependent Child and pay the required premium. Each newborn or adopted child who becomes a Dependent Child while the Primary Insured Person's insurance is in effect will be an Insured Person for 90 days from the date of birth or placement for adoption. Application must be made and the required premium paid for coverage to continue after the 90 day period.

DEFERRED EFFECTIVE DATE

Active Service
The effective date of insurance will be deferred for any Primary Insured Person or any Spouse or Dependent Child who is not in Active Service on the date coverage would otherwise become effective. Coverage will become effective on the later of the date the person returns to Active Service or the date coverage would otherwise have become effective.

Late Enrollment
If application for insurance is not made within 30 days of the date a person is first eligible for coverage, a Life Status Change or during an Annual Re-Enrollment, the applicant will be considered a late enrollee. Coverage for any late enrollee will become effective on the later of the date the Company approves the enrollment form and receives required premium, and the date coverage would otherwise have become effective.

Replacement Coverage
A Primary Insured Person and any Spouse and Dependent Children who was covered under a Prior Plan and who is not in Active Service on the Policy Effective Date as shown in the *Schedule of Benefits* of this Certificate will be insured on that date for the lesser of:

1. the amount of coverage in effect under the Prior Plan on the date it terminated; and
2. the amount of coverage provided under this Certificate.

If the amount of coverage otherwise provided by this Certificate is greater than the amount provided under the Prior Plan, the greater amount will become effective on the first day of the Plan Year after the Primary Insured Person, Spouse or Dependent Child returns to Active Service.

If a Primary Insured Person is required to contribute to the cost of any portion of His or His Spouse's or Dependent Child(ren)'s insurance and is not in Active Service on the effective date of the Policy, coverage will terminate 31 days after the Primary Insured Person returns to Active Service unless He submits an enrollment form and the required initial premium. If the Primary Insured Person selects the amount of benefit for which He is required to pay premium for Himself or any Insured Dependents, the amount in effect under this provision will be the lesser of the amount provided under the Prior Plan and the smallest amount He may select under the Policy.

Annual Re-Enrollment
A Primary Insured Person currently covered under the voluntary portion of the Policy, and a person who is eligible but has not previously enrolled, may increase or become a Primary Insured Person for coverage under this Certificate during an Annual Re-Enrollment Period as agreed to by the Company and the Policyholder. A Primary Insured Person under the Policy may also elect or increase coverage for His Eligible Dependents. Coverage elected during an Annual Re-Enrollment Period will become effective, subject to the Active Service section of the Deferred Effective Date provision, on the first day of the month following the date the Company receives a request and any required premium payment.

Life Status Change
A Life Status Change is an event that the Policyholder determines qualifies a Primary Insured Person to elect or increase benefits provided under this Certificate for Himself and/or His Spouse and Dependent Children. Any change in benefit elections must be made within 31 days of a Life Status Change.

Life Status Changes that qualify a Primary Insured Person to elect or increase His benefits under the Policy include:

1. marriage;
2. loss of a Spouse, whether by death, divorce, annulment or legal separation;
3. birth or adoption of a child, or acquiring a child through marriage; and
4. an increase in cost or a significant reduction or loss of group benefits provided by a Spouse's Plan.

Life Status Changes that qualify a Primary Insured Person to elect or increase benefits under the Policy for His Spouse and Dependent Children include:

1. marriage;
2. birth or adoption of a child, or acquiring a child through marriage; and
3. a significant reduction, increase in cost or loss of group benefits provided by a Spouse's Plan.

Any increases in benefits or added benefits elected under this Life Status Change provision will become effective on the first day of the month following the date the Primary Insured Person applies and agrees to make required contributions.

The Policyholder should seek advice of its tax advisors if Insured Persons may contribute to the cost of any insurance provided by this Certificate with earnings not subject to Federal Income Tax. The Company cannot provide such advice nor offer any opinions on taxation or tax status of any contributions toward cost of insurance.

Effective Date of Changes
Any increase or decrease in the amount of insurance for the Insured Person resulting from a change in benefits provided by the Policy or a change in the Insured Person's covered class will take effect on the date of such change.

Increases will take effect subject to any Active Service requirement.

DATE EMPLOYEE INSURANCE ENDS

Primary Insured Person's Termination Date
A Primary Insured Person's coverage under the Policy will end on the earliest of the following dates:

1. the premium due date, if premiums are not paid when due (subject to the Grace Period provision in the Certificate);
2. at the end of the month following the date the Primary Insured Person ceases to be a member of an Eligible Class;
3. the date the Policy terminates;
4. the last day of the month in which the Primary Insured Person reaches any Lifetime Certificate Maximum;
5. the last day of the month in which the Primary Insured Person fails to pay when due any contribution; or
6. the date the Primary Insured Person notifies the Company in writing to discontinue His coverage;

Insured Dependent's Termination Date
An Insured Dependent's coverage under the Policy ends on the earliest of the following dates:

1. at the end of the month following the date the Primary Insured Person's coverage under the Policy ends;
2. at the end of the month following the date the person ceases to qualify as an Insured Dependent;
3. the premium due date, if premiums are not paid when due (subject to the Grace Period provision in this Certificate);
4. at the end of the month following the date the Insured Dependent is no longer eligible for dependent coverage;
5. the date dependent coverage is no longer provided by the Policy;
6. the last day of the month in which the Insured Person reaches His Lifetime Certificate Maximum;
7. the last day of the month in which the Insured Person fails to pay when due, any contribution;
8. the date the Insured Person notifies the Company in writing to discontinue His Dependent coverage;
9. the date the coverage terminates; or
10. the date the Policy terminates.

Reinstatement of Insurance
If insurance ends because the Primary Insured Person ceases to be eligible for coverage as defined in this Certificate, coverage may be reinstated and no additional waiting period will apply if, within 6 months after the date the insurance ends, the Insured Person becomes a member of an Eligible Class.

Exceptions to Termination of Insurance
If the Primary Insured Person terminates Active Service and if premium payments for His coverage are made when due, He may be considered to be in Active Service, subject to the conditions set forth below:

1. If the Primary Insured Person terminates Active Service due to temporary lay-off or leave of absence, coverage may be continued until the earliest of the following dates:
    a. the date the Policyholder ceases to pay the Primary Insured Person's premiums, or otherwise terminates the insurance;
    b. 3 months from the date the Primary Insured Person ceases to be in Active Service; or
    c. the date the Policy terminates.
2. If the Primary Insured Person terminates Active Service due to injury or Sickness, coverage under the Policy may be continued in accordance with the Continuation of Insurance provision. However, if the Primary Insured Person is not eligible for continuance under the Continuation of Insurance provision and is no longer in Active Service due to injury or Sickness, then the longest they can be covered is for 12 months unless age 65 or older.
3. If the Primary Insured Person terminates Active Service due to retirement, coverage under the Policy may be continued provided:
    a. the Policyholder has elected retiree coverage; and
    b. the Primary Insured Person meets the Policyholder's definition of retired.

Continuation for Leave of Absence or Family Medical Leave
Insurance for a Primary Insured Person and Insured Dependents may be continued until the earlier of the following dates if: (a) a Primary Insured Person is on an Employer-approved leave of absence or an Employer-approved family medical leave; and (b) required premium contributions are paid when due.

1. for an Employer-approved leave of absence: 6 months after the end of the month after the month in which the leave begins; and
2. for an Employer-approved family medical leave 12 weeks in a consecutive 12-month period.

Such continuation will run concurrently with a continuation during any other leave.

Continuation for Military Service
If a Primary Insured Person begins a leave of absence to serve in the armed forces, insurance for the Primary Insured Person and His Insured Dependents will continue until the earlier of the following dates, if the required premium is paid:

1. 18 months; and
2. the day the Primary Insured Person fails to return to work as outlined in the Uniformed Services Employment and Reemployment Rights Act of 1994.

All of the following will apply when coverage is continued under this provision:

1. any change in benefits that occurs during the period of continuation will apply on the effective date of the change;
2. any Active Service requirement will be waived; and
3. the Primary Insured Person will be given credit for the time He was covered under this Certificate prior to the leave.

If a Primary Insured Person does not continue coverage for Himself and His Insured Dependents during such leave and returns to work:

1. the Primary Insured Person and His Dependents will be covered on the date the Primary Insured Person returns to work from the leave. The Primary Insured Person must return to work as outlined in the Uniformed Services Employment and Reemployment Rights Act of 1994; and
2. any portion of an eligibility waiting period that has not been completed will not be credited during the Primary Insured Person's leave.

Continuation of Insurance
If the Primary Insured Person's Active Service ends for any reason, other than termination of employment for gross misconduct, insurance for a Primary Insured Person will continue, if the required premium is paid, until the earliest of the following dates:

1. the 18-month period following the Primary Insured Person's last day of full-time work;
2. for an Insured Dependent, the date the dependent is no longer eligible; or
3. the date the Policy terminates.

Any change in benefits that occurs during a period of continuation will apply on the date the Primary Insured Person returns to Active Service.

ADMINISTRATIVE PROVISIONS

Cancellation
The Company or the Policyholder may cancel this Policy, after the first year or Policy Term, or as of any premium due date, by giving the other party 31 days advance written or authorized electronic notice. Any premium rate guarantee will not affect the Company's or the Policyholder's right to cancel this Policy. Such cancellation terminates all coverage under this Certificate.

If a premium is not paid when due, the Company will cancel this Policy at the end of the last period for which premium was paid, subject to the Grace Period provision. Premium Due Dates are shown in the *Schedule of Benefits.*

Cancellation does not affect a claim when the loss for which the claim is payable occurs before the cancellation date.

All Certificates under this Policy will terminate on the same date as the Policy.

Premiums
Premium rates are expressed in, and premiums are payable in, United States currency. The premiums for coverage under this Certificate will be based on the rates set forth in the *Schedule of Benefits,* the plan and amounts of insurance in effect for Insured Persons and the premium mode selected, as shown in the *Schedule of Benefits*. The Company will provide notifications of premiums due or premium changes, by mail to the most current address in our files, to the Policyholder.

Premium Payment
The total premium paid by the Policyholder is the sum of premiums for all Insured Persons including any amounts contributed toward the cost of the coverage by Insured Persons. The initial premium is due on the Policy Effective Date and each succeeding premium is due on the next succeeding premium due date, as shown in the *Schedule of Benefits,* unless the Policyholder and the Company agree to another mode of premium payment. Premiums are paid at the Company's home office or to the Company's authorized agent.

If any premium is not paid when due, this Policy will be cancelled as of the premium due date of the unpaid premium, except as provided in any applicable Grace Period section.

Grace Period
A Grace Period of 31 days will be provided for the payment of any premium due after the first. During the Grace Period, coverage under this Certificate shall continue in force, unless the Insured Person has given written notice of discontinuance in advance of the premium due date and in accordance with the terms of the Policy. If the required premium is not paid during the Grace Period, coverage will terminate on the last day of the Grace Period. The Insured Person will be liable for the payment of a pro rata premium for the time the Policy was in force during the Grace Period.

Premium Rate Changes
The Company may change premium rates at the end of any Policy Term or any premium rate guarantee period with at least 31 days advance notice mailed to the last known address of the Policyholder. The Company will not increase premium rates more frequently than annually, unless one of the events described below occurs.

The Company may change the premium rate during a Policy Term or during any applicable Premium Rate Guarantee Period if any one of the following occurs:

1. the terms of this Policy change;
2. coverage is reinstated following failure to pay premium during the Grace Period;
3. a change in any federal or state law or regulation is enacted, adopted or amended to the extent it affects the Company's benefit obligations under the Policy;
4. the Policyholder fails to provide sufficient information, as required by the Company, to confirm adequacy of premiums and rates currently being paid; or

5. an acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 10% or more the number of eligible Insured Persons.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

Premium Audit
The Company will have the right to audit books and records of the Policyholder at its place of business and during its regularly-scheduled business hours, in order to determine the accuracy of premiums paid.

GENERAL PROVISIONS

Addition of New Employees
All Employees added to the Eligible Class(es) in the *Schedule of Benefits* are eligible for insurance under the group Policy.

Entire Contract; Changes
The Policy and any attached papers make up the entire contract between the Policyholder and the Company. In the absence of fraud, all statements made by the Policyholder or any Insured Person will be considered representations and not warranties. No written statement made by an Insured Person will be used in any contest unless a copy of the statement is furnished to the Insured Person, or in the event of death or incapacity of the Insured Person, to His beneficiary or personal representative.

No change in the Policy will be valid until approved by one of the Company's executive officers and endorsed on or attached to the Policy. No agent has authority to change the Policy or to waive any of its provisions.

If an enrollment form for an Insured Person is required, it may also be made a part of the Policy at the Company's option.

Certificates
Where required by law, the Company will provide a Certificate of insurance for delivery to the Insured Person. Each Certificate will set forth a statement as to the insurance coverage to which the Insured Person is entitled, to whom the insurance benefits are payable, and a statement as to any family member, Spouse or Dependent's coverage. If family members or Dependents are included in the coverage, the insurer need only issue one Certificate to each family unit.

Incontestability
After an Insured Person has been insured under the Policy for two years during His lifetime, no statement made by the Insured Person, except a fraudulent one, will be used to contest a claim under the Policy. The Company may only contest coverage if the misstatement is made in a written instrument signed by the Insured Person and a copy is given to the Policyholder, the Insured Person or the beneficiary.

30 Day Right to Examine Certificate
For coverage that requires a contribution from the Insured Person, if the Primary Insured Person does not like the Certificate for any reason, it may be returned to the Company within 30 days after receipt. The Company will return any premium that has been paid. In that case the Certificate will be void as if it had never been issued.

Clerical Error
Clerical error, whether by the Policyholder or the Company, will not void the insurance of any Insured Person if that insurance would otherwise have been in effect nor extend the insurance of any Insured Person if that insurance would otherwise have ended or been reduced as provided in the Policy.

Conformity with State Statutes
Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Policy is delivered is hereby amended to conform to the minimum requirements of those statutes.

Misstatement of Fact
If the Policyholder or Insured Person has misstated any fact, all amounts payable under the Policy will be such as the premium paid would have purchased, had such fact been correctly stated.

Noncompliance with Policy Requirements
Any express waiver by the Company of any requirements of the Policy will not constitute a continuing waiver of such requirements. Any failure by the Company to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

Policy Changes
No change in the Policy will be valid until approved by one of the Company's executive officers and endorsed on or attached to the Policy. The Company may agree with the Policyholder to modify a plan of benefits without the Insured Person's consent.

Workers' Compensation
The Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

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

Assignment
An Insured Person may assign all of His rights, privileges and benefits under the Policy without the consent of His designated beneficiary. The Company is not bound by an assignment until the Company receives and files a signed copy. The Company is not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of the Policy.

Physical Examination and Autopsy
The Company, at its own expense, has the right and opportunity to examine the person of any individual whose loss is the basis of claim under the Policy when and as often as it may reasonably require during the pendency of the claim, and to make an autopsy in case of death where it is not forbidden by law.

CLAIMS PROVISIONS

Notice of Claim
Written notice of claim must be given to the Company within 20 days after an Insured Person's loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company, with information sufficient to identify the Insured Person, is deemed notice to the Company.

Claim Forms
The Company will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 15 days after the giving of notice, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include the Insured Person's name, the Policyholder's name and the Policy number.

Proof of Loss
Written proof of loss must be furnished to the Company within 90 days after the date of the loss. In the case of a claim for loss of time for disability, written proof of such loss must be furnished within 30 days after the commencement of the period for which the Company is liable. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as the Company may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than 1 year from the time proof is otherwise required.

Payment of Claims
Upon receipt of due written proof of loss, payments for all losses, will be made to (or on behalf of, if applicable) the Insured Person suffering the loss. If an Insured Person dies before all payments due have been made, the amount still payable will be paid to the first surviving class of the following classes of persons:

1. Spouse;
2. child or children;
3. parents;
4. siblings; or
5. estate of the Insured Person.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to a parent, guardian, or other person actually supporting Him. If the payee has no legal guardian for His property, a payment not exceeding $1,000 may be made, at the Company's option, to any relative by blood or connection by marriage of the payee, who, in the Company's opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

Any payment the Company makes in good faith fully discharges the Company's liability to the extent of the payment made.

Time of Payment of Claims
Benefits payable under the Policy for any loss, other than loss for which the Policy provides any periodic payment, will be paid immediately upon the Company's receipt of due written proof of the loss. Subject to the Company's receipt of due written proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

Economic Sanctions Provision
This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit the Company from providing insurance, including, but not limited to, the payment of claims.

DESCRIPTION OF BENEFITS

This Description of Benefits section describes the Benefits provided by this Policy. Benefit amounts, benefit periods, any applicable aggregate and benefit-specific maximums are shown in the *Schedule of Benefits.* Please read these and the Common Exclusions sections in order to understand all of the terms, conditions and limitations applicable to these benefits.

COVERED SERVICES: The Company will pay the Benefit Amount after the Benefit Waiting Period, both as shown in the *Schedule of Benefits*, for the Covered Services listed below received by an Insured Person while the Policy is in force. To be a Covered Service, the dental service or procedure must be performed by a Dentist, a Physician, a Dental Hygienist or a Specialist. All services must be Medically Necessary.

Benefits will be paid only for the covered charges incurred during a Plan Year which exceed the amount of the Deductible.

A Covered Service is considered received on the following dates:

1. For dentures - the date the first impression is taken.
2. For fixed bridges, crowns, inlays and onlays - the date the teeth are first prepared.
3. For root canal therapy - the date the pulp chamber is opened.
4. For periodontal surgery - the date surgery is performed.
5. For orthodontic services - Benefit is considered as follows: Records - on the date the service is performed; Initial banding - on the date bands are inserted; Monthly treatments - on the date the service is performed.
6. For all other services - the date the service is performed.

The Company shall not pay more for each Insured Person than the Benefit Plan Maximum shown in the *Schedule of Benefits.*

PRE-TREATMENT REVIEW: If the Course of Treatment is expected to exceed the pre treatment amount shown in the *Schedule of Benefits.*, We will require prior review. We must be given the Dentist's treatment plan consisting of a description of the planned treatment with estimated charges and diagnostic x-rays. We will determine Covered Services and state how much We will pay for the treatment. Our determination may suggest an alternate less expensive Course of Treatment if it will produce professionally satisfactory results. If You do not request a pretreatment review, We will pay for the least expensive method of treatment regardless of the method actually used.

The following are the Covered Services that shall be covered under this plan. The Benefit Amount for Covered Services is listed in the *Schedule of Benefits*. The Indemnity Benefit Amount or the Benefit Waiting Period may vary depending on Type of service. The Type of service contained in the *Schedule of Benefits* corresponds to the Type of service listed below.

Type 1 - Preventive & Diagnostic

1. Oral Exams - including diagnosis and prophylaxis, but not more than two examinations during any Plan Year for each Insured Person.
2. X-rays, panoramic or cephalometric:
   a. Full mouth or panoramic X-rays not to exceed one series in any three consecutive Plan Years;
   b. Bitewing x-rays not more than two times per Plan Year for each Insured Person.
3. Sealants:
   a. Limited to children fourteen (14) years of age or younger;
   b. Only for a tooth or teeth posterior to cuspids; and
   c. Not more than one application in a Plan Year per tooth.
4. Fluoride treatment - limited to children fourteen (14) years of age or younger.
5. Space maintainers.-limited to children sixteen (16) years of age or younger.

Type 2 - Major Restorative

1. Crowns, inlays, onlays.
2. Prosthetics - prefabricated crown or cast post and core.
3. Prosthetics, including bridges and dentures as follows:

a. The initial installation, or addition to full or partial dentures, fixed or removable bridgework will be eligible, provided:
    i. The installation or addition was required as a result of an extraction of a natural tooth while insured under the Policy;
    ii. The installation or addition includes the replacement of an extracted tooth or teeth; and
    iii. The denture or bridgework was completed within twelve (12) months following the date of extraction.

    Dentures and bridgework are considered initially installed if they do not replace any existing dentures or bridgework.

4. The replacement or alteration of full or partial dentures, fixed or removable bridgework will be considered for payment when:
    a. Incurred while You are an Insured Person under the Policy; and
    b. Completed within twelve (12) months after one of the following:
        i. An Injury which requires surgical treatment; or
        ii. Oral surgical treatment which involves the repositioning of muscle attachments, or the removal of a tumor, cyst, torus, or redundant tissue.

5. The replacement of a full or partial denture or fixed bridgework when required because of structural change in the mouth or removable bridgework that was no longer serviceable provided the replacement:
    a. Is made five years or more after the installation date of the denture or bridgework;
    b. In no event less than two years after the Insured Person's effective date; and
    c. Performed while insured under the Policy.

Type 3 - Minor Restorative

1. Repair of crown, denture or bridge.
2. Restorations - fillings of amalgam or synthetic process.
3. Relining or rebasing dentures.

Type 4 – Endodontic

1. Root canal; apicoectomy.
2. Root amputation.
3. Therapeutic pulpotomy; retrograde filling; apexification; hemisection.

Type 5 – Periodontics

1. Tissue grafts or bone surgery.
2. Gingivectomy (per quadrant), periodontal scaling, periodontal splinting and root planning.
3. Gingival curettage (per quadrant).
4. Gingivectomy (per tooth).

Type 6 - Oral Surgery

Level 1:

Removal of exostosis; surgical extraction of bony impaction.

Level 2:

Biopsy of oral tissue (soft or hard); alveoloplasty with or without extraction (per quadrant); surgical removal of erupted tooth or residual roots; frenulectomy (frenectomy; frenotomy); excision hyperplastic tissue; removal of impacted tooth (soft tissue).

Level 3:

1. Simple (routine) Extractions.
2. Incision and drainage of abcess (intraoral or extraoral soft tissue); removal of exposed roots.

Type 7 – General Anesthesia and Intravenous Sedation

1. General anesthesia: first half-hour general, each additional ¼ hour.
2. Intravenous sedation.

Type 8 - Comprehensive Orthodontic Treatment

1. Orthodontic appliances - furnishing and attachment of any orthodontic appliance.

Covered Services for Comprehensive Orthodontic Treatment will be paid as follows:

1. An initial amount equal to one-fourth (1/4) of the Covered Services in a treatment plan. This initial amount covers the fee charged in the treatment plan for:
    a. Diagnosis;
    b. Evaluation; pre-orthodontic treatment; or
    c. The insertion of orthodontic appliances.
2. Upon receipt of proof of continued treatment, the balance will be paid in equal installments every 6 months. If the Course of Treatment is less than 18 months, upon notification of the end of treatment, The Company will pay the amount of the balance of the scheduled benefit amount at that date within 30 days.
3. If a treatment plan for Comprehensive Orthodontic Treatment starts before the Insured Person's effective date under the Policy but Covered Services are received after the Insured Person's effective date under the Policy, benefits will be calculated as a pro-rata proportion for the months remaining in the projected Course of Treatment and paid in 3 equal installments every 6 months. If the Course of Treatment is less than 18 months, upon notification of the end of treatment, the Company will pay the amount of the balance of the scheduled benefit amount at that date within 30 days.

BENEFITS AFTER INSURANCE ENDS

If an Insured Person's insurance ends, benefits for the dental services listed below will be paid if:

1. such services began while the Insured Person was insured and the services are completed within 31 days of the date insurance ends, and
2. the Insured Person's insurance ends for reasons other than voluntary termination of the Prior Plan.

Dental benefits may be paid for:

- an appliance, or modification of it, for which the impression was taken while the person was insured under the group policy;
- a crown, bridge or gold restoration, for which the tooth was prepared while the person was insured under the group policy; and
- root canal treatment, if the pulp chamber is opened while the person was insured under the group policy.

CONTINUITY OF COVERAGE UPON TRANSFER OF CARRIERS

These special provisions apply only to those persons who:

- were insured by a given benefit section of a Prior Plan; and
- become insured by a similar benefit section of the group policy on the date such section takes effect.

Benefits

Benefits for charges incurred for Covered Services which are part of a Course of Treatment which began while you were insured by the Prior Plan will be paid up to the lesser of:

- the benefits the group policy would pay; or
- the benefits the Prior Plan would have paid had it stayed in force.

The Company will deduct any benefits actually paid by the Prior Plan under any extension provision. Charges must be incurred by an Insured Person while insured under the group to be considered covered charges. The Company considers a charge incurred:

- for a crown, bridge, or cast restoration, on the date the tooth is prepared;
- for any other prosthetic device, on the date the master impression is made;
- for root canal, on the date the pulp chamber is opened; and
- for all other services, on the date of the exam.

It will end on the date all recommended services have been rendered.

Credit for the Deductible
For the Plan Year in which such person becomes insured, the Deductible will be reduced by the covered charges which were:

- incurred while insured by the Prior Plan; and
- used to satisfy the Deductible for that plan for the same year.

Benefit Waiting Period
The Benefit Waiting Period will be reduced to the extent the person was continuously insured under the corresponding benefit section of the Prior Plan**.**

COMMON EXCLUSIONS

In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Description of Benefits section:

SERVICES NOT COVERED: No benefits will be paid for the following:

1. for services and supplies not listed in the *Schedule of Benefits* or not recognized as essential for the treatment of the condition according to accepted standards of practice or considered experimental;
2. for cosmetic procedures, including but not limited to veneers and bleaching of teeth and procedures performed primarily for cosmetic reasons;
3. for services related to, performed in conjunction with, or resulting from a non-covered procedure;
4. for charges in excess of the Usual and Customary rate;
5. for any treatment program which began prior to the date the Insured Person is covered under the Policy;
6. for crowns, inlays and onlays on teeth that can be restored by direct placement materials.
7. for the replacement of crowns, bridges, dentures, inlays or onlays that can be restored to normal function;
8. for the replacement of crowns, bridges, inlays, onlays or prosthetic appliance within 5 years from the date of last placement;
9. for service or supplies payable under any medical expense portion of an auto or no-fault plan.
10. for any condition paid under any Worker's Compensation Act or similar law;
11. for services applied without cost by any municipality, county or other political subdivision or for which there would be no charge in the absence of insurance;
12. during any Waiting Period the Company requires. When the Insured Person voluntarily ends this insurance without a qualifying event and re-enrolls at a later date, the Waiting Period is 2 years and begins on the date coverage first ended;
13. for services that are applied toward the satisfaction of a Deductible, if any;
14. for services subject to a Waiting Period that were incurred during the Waiting Period;
15. for charges resulting from changing from one provider to another while receiving treatment, or from receiving treatment from more than one provider for one dental procedure to the extent that the total charges billed exceed the amount incurred if one provider had performed all services;
16. for Hospital facility charges for any dental procedure, including but not limited to: emergency room charges, surgical facility charges, Hospital confinement;
17. for drugs or the dispensing of drugs;
18. for oral hygiene instruction; plaque control; acid etch; prescription or take-home fluoride; broken appointments; completion of a claim form; OSHA/Sterilization fees (Occupational Safety & Health Agency); or diagnostic photographs (except for orthodontic purposes);
19. for implants; myofunctional therapy; athletic mouth guards; precision or semi-precision attachments; treatment of fractures, cysts, tumors, or lesions; maxillofacial prosthesis; orthognathic surgery; TMJ dysfunction; cleft palate; or anodontia;
20. for orthodontia, unless included within the *Schedule of Benefits;*
21. for services to replace teeth that were missing (extracted or congenitally) prior to the Coverage Effective Date. This limitation ends after 36 months of continuous coverage on the Plan. Abutment teeth will be reviewed for eligibility of prosthetic benefits;
22. for composite, resin, or white fillings on posterior primary teeth. Benefits will be reduced to that of an amalgam or silver filling;
23. for the replacement of a filling within 24 months of placement, unless for specific health reasons;
24. for the replacement of retainers;
25. for sealants not applied to permanent bicuspid or molar; applied at age 15 or older; applied 3 years from a previous sealant application; applied to a decayed tooth; or
26. for lab fees for higher metals or porcelain crowns, bridges, inlays, or onlays.

NOTICE OF PROTECTION PROVIDED BY

IOWA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Iowa Life and Health Insurance Guaranty Association Act (the "Association") and the protection it provides for policyholders. This safety net was created under Iowa law, located at Iowa Code Chapter 508C, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, health insurance company or health maintenance organization becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Iowa law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

Life Insurance:

- $300,000 in death benefits
- $100,000 in net cash surrender and withdrawal values

Health Insurance:

- $500,000 for health benefit plans (see definition below)
- $300,000 in disability income protection insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits, including net cash surrender and withdrawal values

Annuities:

- $250,000 in the present value of annuity benefits, including net cash surrender and withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000. Special rules may apply with regard to health benefit plans.

"Health benefit plan" is defined in the applicable Iowa law and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

Note: Certain policies and contracts may not be covered or fully covered. If coverage is available, it will be subject to substantial limitations and exclusions. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements under Iowa law.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which the long-term rider relates.

To learn more about the Association and the protections it provides, as well as those relating to group contracts or retirement plans, please visit the Association's website at www.ialifega.org, or contact:

Iowa Life and Health Insurance
Guaranty Association
700 Walnut Street, Suite 1600
Des Moines, IA 50309
(515) 248-5712

Iowa Insurance Division
1963 Bell Ave, Suite 100
Des Moines, IA 50315
(515) 654-6600

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Ratings Inc., Moody's Investors Service, and S&P Global Ratings.

The Association is subject to the supervision of the Commissioner of the Iowa Insurance Division. Persons who desire to file a complaint to allege a violation of the laws governing the Association may contact the Iowa Insurance Division. State law provides that any suit against the Association shall be brought in the Iowa District Court in Polk County, Iowa.

Insurance companies and agents are not allowed by Iowa law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Iowa law, then Iowa law will control.

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

AXIS Insurance Company values its relationship with you. Protecting the privacy of the information we have about you is of great importance to us. We want you to understand how we protect the confidentially of information as well as how and why we use and disclose it. We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to this information. "Protected health information" includes any individually identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your healthcare.

This privacy policy applies to student health policies underwritten by AXIS Insurance Company. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice. We reserve the right to change the terms of this notice, and should that occur, we will provide you with a copy of the new notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We use and disclose your Protected Health Information (PHI) for the purposes of your treatment, for payment and for health care operations. Not every use or disclosure in a category is listed. However all of the ways that we may use or disclose PHI will fall within one of these categories.

Your Authorization: Except as outlined below, we will not use or disclose your PHI for any purpose unless you have signed a form authorizing use or disclosure. You may take away this authorization at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your authorization, we cannot undo any actions we took before you told us to stop.

For Payment: We use and disclose PHI as necessary for payment purposes. For example, we may use your PHI to process a claim or may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and disclose PHI for our health care operations such as customer service, premium rating, fraud and abuse prevention and detection, and other functions related to your health policy. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To Others: You may authorize us in writing to give your PHI to someone else for any reason. Also, if you are present, and provide authorization, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are unavailable, incapacitated, or facing an emergency medical situation, we may share limited PHI with a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also use or disclose your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared for any purpose as required by law.

We may share PHI with the sponsor of the plan or use in the administration of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

YOUR HIPAA PRIVACY RIGHTS

Access to Your PHI

You have the right to obtain a copy and inspect specific items of your PHI, such as your policy or claim information, for as long as we maintain it. We may deny your request to access certain PHI, as permitted or required by law. We may require your request for access in writing. Your request for access should contain as much detail as possible regarding the PHI you wish to review. We may charge a reasonable fee for access to your PHI.

Amendments to Your PHI

You have the right to request that the PHI we maintain about you be amended or corrected if you believe it is incorrect. We are not legally obligated to make all requested amendments but will give each request appropriate consideration. Requests for amendment must be in writing and must state the reasons for the amendment request.

Accounting for Disclosures of Your PHI

You have the right to request an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. Requests must be made in writing. We are not legally obligated to provide an accounting of every disclosure but will give each request appropriate consideration. The accounting will not include disclosures made prior to June 1, 2011.

Restrictions on Uses and Disclosures of Your PHI

You have the right to request restrictions on certain uses and disclosures of your PHI for treatment, payment, or health care operations by notifying us of your request for a restriction in writing. We are not legally required to agree to your restriction request but will give each request appropriate consideration.

Confidential Communication of PHI

You have the right to request to receive communications from us regarding your PHI by another method of contact or at an alternative address. We will accommodate reasonable requests, which must clearly state that disclosure of all or part of the information could endanger your health or safety.

HIPAA PRIVACY NOTICE

Right to a Copy of the Notice
You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Potential Impact of Other Applicable Laws
HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints
If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services in Washington, D.C. We will not take action against you for filing a complaint.

Contact Information
If you have questions or need further assistance regarding this Notice, or wish to exercise any of the abovementioned rights, you may write to us at

Administrative Address:
AXIS Insurance Company
10000 Avalon Blvd., Suite 200
Alpharetta, GA 30009
888.870.AXIS (2947)
General questions - please send to USSales.AccHealth@axiscapital.com

Please include your name, address, plan sponsor, and policy number in any correspondence.

Effective June 1, 2011

OFAC NOTICE

Payment of claims under any insurance policy issued shall only be made in full compliance with all United States economic or trade and sanction laws or regulations, including, but not limited to, sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC").