DENTAL Wisconsin Preferred Provider PLAN
CERTIFICATE
For
Wisconsin State Employees and Annuitants

Please read this certificate, including the Schedule of Benefits and all endorsements, if any, carefully so you know and understand your coverage.

Use Your EPIC Identification Card. Please be sure to show your EPIC identification card each time you or any of your covered dependents go to your dentist, physician or licensed dental professional.

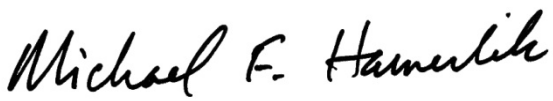
This certificate is not the contract of insurance. It is merely evidence of insurance provided under the group insurance policy (hereinafter called "group policy" or "policy") issued by EPIC to the group policyholder (hereinafter called "group policyholder" or "policyholder"). This certificate describes the essential features of such insurance. This certificate replaces and supersedes all certificates and endorsements thereto which we may have previously issued to you prior to the effective date of this certificate.

The insurance described in this certificate limits charges for covered expenses to the amounts we determine as being reasonable. This amount may be less than the amount billed. Please see the definition of Acharge@ in Section II. Definitions. If you would like more information, please call the telephone number shown on your EPIC Identification Card.

EPIC, in performing its obligations under the policy, is acting only as a health insurer with respect to the policy and is not in any way acting as a plan administrator, a plan sponsor or a plan trustee for the purposes of the Employee Retirement Income Security Act (ERISA), as amended, or any other federal or state law.

The group policy is issued by EPIC and delivered to the policyholder in the state of Wisconsin. All terms, conditions and provisions of the group master policy, including, but not limited to, all exclusions and coverage limitations contained in the group policy, are governed by the laws of the state of Wisconsin. All benefits are provided in accordance with the terms, conditions and provisions of the group master policy, including all endorsements, if any, attached to this certificate, and applicable Wisconsin laws and regulations.

THE EPIC LIFE INSURANCE COMPANY



Michael F. Hamerlik, President

TABLE OF CONTENTS

I. GENERAL INFORMATION

A. General Description of Coverage

EPIC certifies that a group policy has been issued to a group insuring certain employees or annuitants of the group. We call the group the policyholder. Those persons to whom we've issued certificates are called covered employees or annuitants. Covered employees or annuitants are also called members. If a covered employee or annuitant is issued limited family or family coverage under the group policy, his/her eligible dependents whom we've approved for coverage are called members. The group policy forms a contract between us and the policyholder. We'll provide the insurance described here under the terms, conditions and provisions of that contract. Subject to that contract, each member is insured for the coverage described in this certificate. Please see Section XVIII. J. Entire Contract.

This certificate describes the two benefit levels available to members for covered expenses under the policy. One benefit level applies when you receive covered dental services provided by a preferred provider. The other benefit level applies when you receive covered dental services provided by a provider other than a preferred provider.

B. Coverage

Coverage is subject to terms, conditions, exclusions, limitations, and all other provisions of the policy. As a certificate, this document describes the essential benefits of the insurance provided by the policy.

This certificate replaces and supersedes all certificates and endorsements thereto which we may have previously issued to the covered employee or annuitant prior to the effective date of this certificate.

C. How to Use this Certificate

This certificate, including its Schedule of Benefits and all endorsements, should be read carefully and completely by you. You should also review this certificate periodically. The provisions of this certificate are interrelated. This means that each provision is subject to all of the other provisions. Therefore, reading just one or two provisions may not give you a clear or full understanding of your coverage under the policy.

Each term used in this certificate has a special meaning. These terms are defined for you in Section II. Definitions. By understanding these definitions, you will have a clearer and better understanding of your coverage under the policy as described in this certificate by us.

From time to time, the policy may be amended by us. That means your coverage under the policy will change to the extent described in the endorsement, as of the effective date of that endorsement. When that happens, a new endorsement for this certificate will be sent by us to the policyholder for its delivery to each covered employee or annuitant. This certificate should be kept in a safe place for your future reference.

D. Covered Expenses

Benefits are payable only for charges for covered expenses under the policy. The fact that a health care provider has performed or prescribed a treatment or service or the fact that it may be the only available treatment or service for an illness or injury does not mean that the treatment or service is covered under the policy. EPIC has the sole and exclusive right to interpret and apply the policy's terms, conditions, limitations, exclusions, and all other provisions of the policy, including, but not limited to, making factual determinations under the policy's provisions, including, but not limited to, whether benefits are payable. At any time, we may, at our sole discretion, give certain discretionary authority to other persons or entities providing administrative services to us in regard to the policy. We reserve the right to change, interpret, modify, remove or add benefits, or terminate the policy at our sole discretion, without giving prior notice to you, or getting your approval. Other than EPIC, no person has any authority to make any oral changes or amendments to the policy. Please also see Section XIII. K. Waiver and Change.

In certain circumstances for purpose of overall cost savings or efficiency, we may at our sole discretion, pay benefits for dental services which are not covered under the policy, to the limited extent provided in Section IV. A. 3. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in any other case, whether similar or dissimilar.

We may, at our sole discretion, arrange for various persons or entities to provide administrative services in regard to the policy including claims processing. Their identity and the nature of the services being provided by them may be changed by us at any time at our sole discretion, and without giving prior notice to you, or getting your approval. By accepting this certificate, you agree to and must cooperate fully with those persons or entities in the performance of the responsibilities.

II. DEFINITIONS

In this certificate, the following terms shall mean:

Active Work/Actively at Work: When an employee is performing all of the full-time duties of his/her principal occupation in his/her job with the policyholder for the required number of hours per week as shown in the policyholder's current EPIC application for coverage, and paid a reasonable wage as determined by us. These duties must be performed at the policyholder's place of business, except to the extent that the employee must travel to perform his/her duties. If the employee is not totally disabled on the effective date, then the employee shall be deemed to be actively at work on: (a) each day of a paid vacation; (b) approved leave of absence or (c) a regularly-scheduled non-work day, provided that, in either case, he/she has performed all of the full-time duties of his/her principal occupation in his/her job on a full-time basis on his/her entire last regularly scheduled work day prior to such date. Not applicable for Annuitants.

Alternate Treatment: If, based on the generally-accepted national standards of dental practice as determined by us, there are other procedures or materials that will provide suitable treatment, covered dental expenses will be limited to those which are customarily employed and recognized by the dental profession in the United States to be appropriate methods of treatment for the member's illness or injury covered under the policy, taking into account the total current oral condition of the member who is the patient.

Annuitant: A WRS Member who has retired and is eligible for group health insurance plans under the WRS, or is the surviving Spouse of an Annuitant. Eligible Annuitants include those who meet at least one

of the following criterion:

a. Receives a disability annuity under Wis. Stat. §40.63;

b. Receives a disability benefit under Long Term Disability Insurance (LTDI) under Subch. III of Wis. Admin. Code Ch. 50;

c. Receives duty disability benefits under Wis.Stat.§ 40.65;

d. Left State service with at least 20 years of creditable service under the WRS, regardless of age; or, has received a retirement lump sum payment.

It does NOT include beneficiaries who were not the Spouse of the Subscriber, nor those who have received a lump sum after separation (vs. retirement.)

A covered employee who becomes an immediate annuitant upon retirement or a surviving spouse of a covered employee shall be allowed to continue under the group plan at group plan rates including any portion paid by the policyholder, providing application is made within 60 days from the date the covered employee becomes an annuitant.

Basic Plan: (a) the State Group Health (SGH) or any other plan or plans, other than this certificate, providing benefits or services to a member arranged through the policyholder and any benefits paid or (b) or any other plan offered by an employer.

Board: Group Insurance Board (Board) that oversees benefits provided under Wisconsin Statutes, Chapter 40. Some sources or members may call the Board the "G.I.B."

Calendar Year: The period that starts with the effective date shown in our records and ends on December 31st of such year. Each following calendar year shall start on January 1st of any year and end on December 31st of that year.

Certificate: The document issued by us to a covered employee or annuitant who is insured under the policy issued by us to the policyholder. It is not a contract of insurance, but only evidence of coverage, and describes the essential features of the insurance provided by the policy.

Charge: An amount for a dental service provided to you by a health care provider that is reasonable, as determined by us, when taking into consideration, among other factors (including national sources) determined by us, amounts charged by health care providers for similar dental services when provided in the same geographic area. The term "area" means a county or other geographical area which we determine is appropriate to obtain a representative cross section of such amounts. For example, in some cases the "area" may be an entire state. In some cases the amount we determine as reasonable may be less than the amount billed. Charges for dental services are incurred: (a) on the date of insertion for a crown, inlay, onlay, implants, bridge or partial or complete dentures; (b) on the date the root canal is completed for root canal therapy; and (c) on the date a member receives the dental service for all other dental services.

Complaint: Any expression of dissatisfaction expressed to the Insurer by the insured or an insured's authorized representative, about an Insurer or its providers with whom the Insurer has a direct or indirect contract.

Cosmetic Surgery: Surgery performed to reshape normal structures of the body in order to improve either the patient's appearance or self-esteem.

Cosmetic Treatment: Health care services used to improve either the patient's physical appearance or self-esteem.

Covered Annuitant: An annuitant eligible for coverage under the policy, who has properly enrolled, and is approved by us for coverage under the policy.

Covered Employee: An employee eligible for coverage under the policy who has properly enrolled and is approved by us for coverage under the policy.

Deductible: The amount of charges for covered expenses which you are required to pay to a dentist, physician, licensed dental professional or health care provider for certain dental services covered under the policy received from the dentist, physician, licensed dental professional or health care provider in a calendar year before benefits are payable under the policy.

Dental Services: Dental treatment or services provided by one of the following to treat the member's illness or injury: (a) a dentist of a member's choice; (b) a physician of a member's choice and such physician is acting within the lawful scope of practice of a dentist; and (c) a licensed dental professional performing related services requested by a dentist or physician acting within the lawful scope of practice of a dentist.

Dentally Necessary: The dental service provided by a dentist, physician, licensed dental professional or health care provider that is required to identify or treat a member's illness or injury and which is, as determined by us: (a) consistent with the symptom(s) or diagnosis and treatment of the member's illness or injury; (b) appropriate under the standards of generally-accepted national standards of dental practice to treat that illness or injury; (c) not solely for the convenience of a member, dentist, physician, licensed dental professional, or health care provider; and (d) the most appropriate dental service which can be safely provided to the member and accomplishes the desired end result in the most economical manner. Dentally necessary services shall include preventive services as described in the policy.

Dentist: A person who has received a degree in dentistry and is licensed to practice dentistry in the state in which he/she is located and provides dental services while he/she is acting within the lawful scope of his/her license.

Department: The State of Wisconsin Department of Health and Social Services.

Dependent: A covered employee's or annuitant's:

a. Spouse;

b. Child;

c. Legal ward who becomes a legal ward of the covered employee or annuitant, covered employee's or annuitant's spouse prior to age 19, but not a temporary ward;

d. Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896;

e. Stepchild;

f. Grandchild if the parent is a dependent child. The dependent grandchild will be covered until the end of the month in which the dependent child turns age 18.

g. A child born outside of marriage becomes a dependent of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with the Department of Children and Families (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The effective date of coverage will be the date of birth if a statement or court order of paternity or a court order is filed within 60 days of the birth.

h. A spouse and a stepchild cease to be dependents at the end of the month in which a marriage is terminated by divorce or annulment. A domestic partner and his or her child(ren) cease to be dependents at the end of the month in which the domestic partnership is no longer in effect.

i. All other children cease to be dependents at the end of the month in which they turn 26 years of age, except that:

(1) An unmarried dependent child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible dependent, regardless of age, as long as the child remains so disabled and he or she is dependent on the subscriber (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. EPIC will monitor eligibility annually, notifying the dependent when terminating coverage prospectively upon determining the dependent is no longer so disabled and/or meets the support requirement. EPIC will assist the department in making a final determination if the subscriber disagrees with EPIC's determination.

(2) After attaining age 26, as required by Wis. Stat. § 632.885, a dependent includes a child that is a full-time student, regardless of age, who was called to federal active duty when the child was under the age of 27 years and while the child was attending, on a full-time basis, an institution of higher education.

Direction: Verbal or written instructions, standing orders or protocols issued by a dentist, physician, licensed dental professional or health care provider.

Employee: Has the meaning of Eligible Employee, as defined in Wis. Stat. §40.02(25)(b). It includes state employees eligible for the Wisconsin Retirement System,elected state officials, and graduate and teaching assistants, employed at least 1/3 time and expected to be employed for at least six months.

Employer: The Employer's office of Human Resources, Payroll *and/or* Benefits, and the Payroll Center that serves that WRS participating State Agency.

Enrollment Period: The period beginning immediately following an eligible employee's or annuitant's eligibility date through the 30th day immediately following that eligibility date. For additions to, or changes in, coverage, the enrollment period is stated in Section III. Effective Date.

EPIC: The EPIC Life Insurance Company with its principal office located in Madison, Wisconsin.

ETF: Department of Employee Trust Funds.

Expedited Grievance: Means a grievance where any of the following applies:

a. The duration of the standard resolution process will result in serious jeopardy to the life or health of the member or the ability of the member to regain maximum function.

b. In the opinion of a physician with knowledge of the member's medical condition, the insured is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.

c. A physician with knowledge of the member's medical condition determines that the grievance shall be treated as an expedited grievance.

Experimental/Investigative: The use of any service, treatment, procedure, facility, equipment, drug or device for a member's illness or injury that: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized under generally-accepted national standards of dental practice to treat that illness or injury, as determined by us.

The criteria that we use for determining whether or not a service, treatment, procedure, facility, equipment, drug or device is considered to be experimental or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug or device is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug or device is generally accepted to treat that illness or injury by the dental profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug or device; (d) whether other, more conventional methods of treating the illness or injury have been exhausted by the member; (e) whether the service, treatment, procedure, facility, equipment, drug or device is dentally necessary; (f) whether the service, treatment, procedure, facility, equipment, drug or device is recognized for reimbursement by Medicare, Medicaid and other insurers and self-funded plans.

Family Coverage: Means coverage applies to a covered employee or annuitant, his/her eligible spouse and his/her eligible dependent children. To be covered, a dependent must be properly enrolled and approved by us for coverage under the policy. We must also receive timely the appropriate premium to pay for his/her coverage. When referred to in this certificate, family coverage also includes limited family coverage.

Full-Time Student: An adult child of a member who meets the following criteria:

a. The child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education;

b. The child was under the age of 27 when called to federal active duty; and

c. Within 12 months after returning from federal active duty, the child returned to an institution of higher education on a full-time basis, regardless of age.

The adult child must: (1) attend an accredited school for the number of credits, hours, or courses required by the school to be considered a full-time student; or (2) attend two or more accredited schools for credits toward a degree, which, when combined equals full-time status at one of the schools; or (3) participate in either an internship or student teaching during the last semester of school prior to graduation, if the internship or student teaching is required for his or her degree. The adult child continues to be a full-time student during periods of vacation or between term periods established by the school.

Functional Impairment: a deficit in a member's ability to perform the basic activities of daily living (ADLs), such as dressing, bathing, and eating or the instrumental activities of daily living such as using transportation, shopping or handling finances. The presence of a psychological condition alone will not entitle a member to coverage for plastic or reconstructive surgery.

Grievance: Means any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, a member.

Group Policy/Policy: The group insurance policy issued by us to the Board known as the policyholder. In it, we agree to insure members of the group policyholder for future dental care services covered by the policy through benefit payments, subject to the terms, conditions and provisions of the policy.

Health Care Provider: Any person, institution or other entity licensed by the state in which he/she or it is located to provide dental services covered by the policy to you, within the lawful scope of his/her or its license.

Health Care Services: Medical or dental treatment, services, procedures, drugs or medicines, devices, or supplies directly provided to you and covered under the policy, except to the extent that such treatment, services, procedures, drugs or medicines, devices, or supplies are limited or excluded under the policy.

HIPAA: Health Insurance Portability and Accountability Act, a United States federal law that includes privacy standards to protect personal health information.

Hire Date: For purposes of insurance effective date, the first day of active benefits- eligible employment upon hire, also called eligibility date.

Illness: A disorder or a disease of the oral cavity.

Immediate Family: A covered employee's or annuitant's spouse, natural and adopted children, parents, grandparents, brothers, and sisters, and the spouses of such persons.

Incidental: associated services or items which are integral to the performance of another service or item, or which does not add significant time or effort to the other service or item.

Injury: Damage to the oral cavity caused by an accident. The oral cavity damage must result directly from the accident and independently of all other causes. The injury and treatment must occur while a member is covered under the policy.

Insurer: Company providing an Insurance plan approved by the Board as an optional, Employee-pay-all benefit.

It's Your Choice: It's Your Choice (IYC), is a designated enrollment period that is offered to Employees, Annuitants, surviving spouses and dependents who are eligible under the State of Wisconsin Group Health Insurance Program. It is an opportunity to enroll, change plans, change coverage level, or cancel coverage. Changes made become effective January first of the following year. See also Open Enrollment.

Late Enrollee: An eligible employee, annuitant or dependent of an eligible employee/annuitant, who does not request coverage under the policy during the enrollment period during which the person is entitled to enroll for coverage under the policy and who subsequently requests coverage under the policy.

Leave of Absence: Any period in which an Employee is not working for, or receiving earnings from, the Employer and has not terminated the Employer-Employee relationship as defined in Wis. Stat. § 40.02 (40). For the purpose of Optional Insurance, a Leave of Absence ends when the Employee has returned to active work.

Licensed Dental Professional: A person licensed by the state in which he/she resides and provides dental services requested by a dentist or physician while he/she is acting within the lawful scope of his/her license.

Limited Family Coverage: Means coverage applies to a covered employee or annuitant and his/her eligible spouse or coverage applies to a covered employee or annuitant and his/her eligible dependent child. To be covered, a dependent must be properly enrolled and approved by us for coverage under the policy. We must also receive the appropriate premium for him/her.

Medicaid/Medical Assistance: benefits available under state plans pursuant to Title XIX of the Social Security Act of 1965, as amended.

Medicare: Benefits available under Title XVIII of the Social Security Act of 1965, as amended.

Member: Means a member of a household enrolled in an insurance plan, or eligible for COBRA, or depending on context in this document may mean Member of the Wisconsin Retirement System.

New Entrant: An eligible employee, or dependent of an eligible employee, who: (a) becomes part of the employer group after the commencement of the employer's initial enrollment with us under the policy, provided he/she enrolls for coverage under the policy within 30 days immediately following the end of his/her eligibility date; or (b) is a spouse or dependent child who a court orders be covered under the policy and who requests enrollment under the policy.

Optional Insurance Plan: Has the same meaning as Plan.

Open Enrollment: A defined period during which eligible Employees and/or annuitants may enroll, change, or cancel participation in any specific insurance plan. The time frame is established by the Board, usually for 4 weeks beginning in early to mid- October. For optional insurance, the opportunity to enroll may be further designated by the insurer, only in agreement with the Board, to limit the employment status or other characteristics that offer eligibility to enroll.

Physician: A person who received a degree in medicine and is a medical doctor or surgeon licensed by the state in which he/she is located and provides professional services while he/she is acting within the lawful scope of his/her license. When we are required by law to cover the services of any other licensed medical professional

under the policy, a physician also includes such other licensed medical professional who: (a) is acting within the lawful scope of his/her license; (b) performs a service which would be payable under the policy; and (c) performs a service that is required by law to be a covered expense under the policy.

Pre-Authorization: A written treatment plan in advance of treatment when amounts to be billed for a proposed covered dental service would exceed $200.

Professional Services: Services directly provided to you by a physician of your choice to treat your illness or injury. Such services also include services provided by a certified registered nurse anesthetist, registered or licensed practical nurse, laboratory/x-ray technician and physician assistant, provided such person is lawfully employed by the supervising physician or the facility where the service is provided and he/she provides an integral part of the supervising physician's professional services while the physician is present in the facility where the service is provided. With respect to such services provided by a registered or licensed practical nurse, laboratory/x-ray technician and physician assistant, such services must be billed by the supervising physician or the facility where the service is provided.

Plan: Insurance plan approved by the Board as an optional, Employee-pay-all benefit, and/or benefit available to Annuitants.

Preferred Provider: A dentist, physician or licensed dental professional who has entered into a written preferred provider agreement with the provider network shown on your EPIC Identification card. The Preferred Provider Directory is available on the Internet at www.epiclife.com or by request from EPIC. Please note that preferred providers may change periodically. While the on-line Preferred Provider Directory is updated frequently, the presence of a provider's name in the listing does not guarantee or mean that that specific provider participates in that network at the same time that a member receives any service from that provider. The member may be required to pay a larger portion of the cost of his/her covered dental service if he/she sees any provider who is not a preferred provider at the time he/she receives the dental service.

Provider: A dentist, physician or licensed dental professional.

Qualifying Event: Life event that provides an opportunity for a Subscriber to add, cancel, or change coverage. Events can include: marriage, birth or adoption, legal placement of a ward, a dependent child turning age 26, divorce or annulment, leave of absence, death, and loss of comparable coverage. However, not every *event* listed here allows each type of change. See specific sections for enrollment, change, and cancellation. Source: HIPM and Internal Revenue Code.

Records: Electronic data or paper files with Subscriber-related information, maintained by the Employer, payroll center, or Insurer.

Single Coverage: Means coverage applies only to a covered employee or annuitant.

Sound Natural Teeth: Teeth that: (a) are organic and formed by the natural development of the human body; (b) are not manufactured; (c) have not been extensively restored; (d) have not become extensively decayed or involved in periodontal disease; and (e) are not more susceptible to injury than whole natural teeth.

Special Enrollment Period: the period of time when a late enrollee is allowed to apply for coverage under the

policy, during the State of Wisconsin's It's Your Choice Open Enrollment period. This period of time is determined by the policyholder and approved by us.

Spouse: Person in a marriage recognized in the state of Wisconsin.

STAR: "State Transforming Agency Resources." The automated payroll and benefits system for State agencies used by central payroll (most administrative agencies) and the legislature.

State Group Health or SGH: Group health care benefits for Employees, Annuitants, and their Dependents eligible for coverage offered by the Group Insurance Board as required by Wis. Stat. § 40.51 and 40.52.

Subscriber: An active Employee or Annuitant who has enrolled in an Optional Insurance plan, who is not enrolled as the Dependent of another Subscriber.

Supplies: Dental supplies or other supplies directly provided to you by a provider, as determined by us.

Totally Disabled/Total Disability: Means you are unable due to illness or injury to perform the essential functions of any full-time job with the policyholder, as determined by us. You are not totally disabled if you are working on either a full-time or part-time basis for wage or profit for anyone, including working for yourself. For dependents and retired employees, this means the person's inability due to illness or injury to carry on most of the normal activities of a person of the same age and sex, including, but not limited to, being unable to work on either a full-time or part-time basis for wage or profit for anyone, including working for himself/herself, as determined by us. The totally disabled person must be under the regular care of a physician. We have the right to examine such person, including having health care providers examine that person, as often as we reasonably require for us to determine whether or not that person is totally disabled.

Treatment Plan: A dentist's or physician's report on a form acceptable to us which: (a) itemizes the dental services recommended by the dentist or physician as being dentally necessary for a member; (b) shows the dentist's or physician's billed amount for each dental service; and (c) is accompanied by supporting pre-operative x-rays or other diagnostic records when required or requested by us.

UWHC: University of Wisconsin Hospital and Clinics, an Employer with its own payroll system. Has its own optional dental insurance, and a separate AD&D contract.

UWS: University of Wisconsin Systems, an Employer with its own payroll system. Does not offer the exact array of Plans as the balance of state agencies.

Ward: An individual for whom a legal guardian has been appointed, under Chapter 54.1O Wis. Stats. Also "legal ward."

We, Us Our: The EPIC Life Insurance Company.

WEDC: Wisconsin Economic Development Corporation, an Employer with its own payroll system.

WHEDA: Wisconsin Housing and Economic Development Authority, an Employer with its own payroll system.

WRS: Wisconsin Retirement System.

You, Your: A member.

III. EFFECTIVE DATE

If application for coverage is properly made on our application form by an eligible employee or annuitant and the required premium for his/her coverage is submitted in advance to EPIC, the effective date of single, limited family or family coverage to be issued under the policy for that employee or annuitant and his/her dependents, if any, shall be determined by us as follows:

A. Employees

An eligible employee shall become covered under the policy as an insured on the latest of: (1) the policy's policy effective date; or (2) the date he/she becomes eligible, provided the employee applies within 30 days of his/her eligibility date. If the eligible employee applies more than 30 days following his/her eligibility date, that employee will be considered a late enrollee and eligible to apply for coverage as stated in subsection H Late Enrollee below.

The eligible employee must be actively at work or on an approved leave of absence and not totally disabled on his/her effective date of coverage under the policy. However, if an otherwise eligible employee is not actively at work on the date his/her coverage would otherwise become effective under the policy, his/her coverage shall not become effective until the earliest later date he/she is eligible and is actively at work with the policyholder.

B. Annuitant

An eligible annuitant shall become covered under the policy as a member on the first day of the calendar month following the date he or she becomes eligible as an annuitant, provided the annuitant applies within 60 days of his or her eligibility date. If the eligible annuitant applies more than 60 days following his or her eligibility date, such application will be returned and his or her coverage shall not become effective under the policy. That annuitant will be considered a late enrollee and eligible to apply for coverage as stated in subsection H . Late Enrollees below.

C. Dependents

If an eligible employee or annuitant applies for family coverage or limited family coverage under the policy, each of his or her eligible dependents shall become insured as a member on the latest of: (1) the date the eligible employee or annuitant becomes covered under the policy as a covered employee or annuitant; (2) the date the dependent becomes eligible, provided the eligible employee or annuitant applies within 30 days of his or her dependent's eligibility date (60 days for newborns and adopted children). If the eligible employee or annuitant applies more than 30 days following his or her dependent's eligibility date (60 days for newborns and adopted children), that dependent will be considered a late enrollee and eligible to apply for coverage as stated in subsection H . Late Enrollees.

However, if an eligible dependent who would otherwise become insured is confined in a hospital or at

home or is totally disabled on the date his or her coverage would otherwise become effective under the policy, his or her coverage shall not become effective until the earliest later date he or she ceases to be confined in a hospital or at home and is not totally disabled.

If family coverage is in effect on the date of birth of the covered employee's or annuitant's newborn child or the date the covered employee or annuitant adopts a child, coverage for such child is effective as of that date of birth of the newborn child or, for an adopted child: (1) on the date that a court makes a final order granting the covered employee or annuitant adoption of the child; or (2) on the date that the child is placed for adoption with the covered employee or annuitant, whichever occurs first.

In the event of a divorce, each eligible employee or annuitant, may cover any eligible dependent children (not former stepchildren) under family coverage. Coverage of the same dependents by both parents would be subject to Section X. COORDINATION OF BENEFITS.

D. Changing From Single Coverage or Limited Family Coverage to Family Coverage Due to Marriage.

If a covered employee or annuitant has single coverage or limited family coverage and wishes to change to family coverage to add an eligible dependents because of his/her marriage, he/she must apply using our application form and pay the required premium to us within 30 days of the date of such marriage. If you properly apply within that 30-day period as required by us, the effective date for family coverage will be the date of the marriage. If the covered employee or annuitant applies after that 30-day period, such dependents will be considered late enrollees and eligible to apply for coverage as stated in subsection H . Late Enrollee below..

However, if an otherwise eligible dependent is confined in a hospital or at home or is totally disabled on the date his/her coverage would become effective under the policy, his/her coverage shall not be effective until the earliest later date he/she ceases to be confined in a hospital or at home and is not totally disabled.

E. Changing from Single Coverage or Limited Family Coverage to Family Coverage due to a Child's Birth

If a covered employee or annuitant has single coverage or limited family coverage, coverage is provided for his/her newborn natural child from the moment of that child's birth and for the next 60 days of that child's life immediately following that child's date of birth. Prior to the end of that 60-day period, the covered employee or annuitant must notify us about the child's birth and pay the required premium for that child's coverage during that child's 60-day period. If the covered employee or annuitant fails to notify us and pay the required premium to us, coverage for his/her newborn natural child shall terminate at the end of that child's 60-day period, unless the covered employee or annuitant applies for limited family or family coverage using our application form as described below.

If a covered employee or annuitant wishes to change to family coverage to add a newborn natural child, he/she must apply using our application form either: (1) within the first 60 days after the birth of his/her natural child and pay the required premium; or (2) within one year after the birth of his/her natural child and pay all past-due premiums The effective date for such family coverage will be the date of that

child's birth.

If the covered employee or annuitant fails to do either (1) or (2) above, such application will be returned and your newborn natural child will not be covered under the policy . If the covered employee or annuitant applies after that 60-day period, your new dependent will be considered a late enrollee and eligible to apply for coverage as stated in subsection H. Late Enrollee below.

F. Changing from Single Coverage or Limited Family Coverage to Family Coverage Due to Adoption

If a covered employee or annuitant has single coverage or limited family coverage and wishes to change to family coverage to add a new eligible dependent because of his/her adoption of a child or a child placed for adoption, the covered employee or annuitant must apply using our application form and pay the appropriate premium within 60 days of the date of such adoption or placement for adoption. In the case of a child placed for adoption with the covered employee or annuitant, the meaning of "placed for adoption" is defined in Section 632896, Wisconsin Statutes, as amended. If the covered employee or annuitant properly applies within that 60-day period as required by us, the effective date for such family coverage will be: (1) on the date a court makes a final order granting the covered employee's or annuitant's adoption of the child; or (2) on the date that the child is placed for adoption with the covered employee or annuitant, whichever occurs first. If the covered employee or annuitant applies after that 60-day period, your new dependent will be considered a late enrollee and eligible to apply for coverage as stated in subsection H . Late Enrollee below.

If adoption of a child who is placed for adoption with the covered employee or annuitant is not finalized, the child's coverage will terminate when the child's adoptive placement with the covered employee or annuitant terminates. . The new dependent will be considered a late enrollee and eligible to apply for coverage as stated in subsection I. Late Enrollee below.

G. Adding Dependent Due To Court Order

To the extent required by Section 632.897 (10) (am), Wisconsin Statutes, as amended, if a court orders a covered employee or annuitant with single, limited or family coverage to provide coverage for health care expenses for his/her dependent child, the covered employee or annuitant will be issued limited family or family coverage to include that child effective as of the date that court order is issued unless another coverage date is contained in that order, provided that child is eligible for coverage under the policy as determined by us, without that child being subject to our health underwriting requirements, including not having to submit evidence of insurability to us. Written application for that child's coverage must be made by either the covered employee, annuitant, or the child's other parent, the department, or the county designee under Section 59.53 (5), Wisconsin Statutes, as amended, using our application form.

The completed form, a copy of the court order and the appropriate premium for his/her coverage must be submitted to us as soon as reasonably possible after the court order is issued to the covered employee or annuitant. As long as the covered employee or annuitant is eligible for coverage under the policy, that child's coverage will continue under the policy until the date that court order is no longer in effect or the date that child has coverage under another group policy or individual policy that provides comparable

health care coverage, as applicable, unless that child's coverage ends sooner in accordance with the Section XII. When Coverage Ends. The covered employee or annuitant must notify us in writing about that court order ending and/or that other coverage becoming effective for that child as soon as reasonably possible after the covered employee or annuitant becomes aware of that fact.

H. Late Enrollees –See endorsement E11894

A late enrollee may apply for coverage during an open enrollment period determined by the policyholder and approved by us. A late enrollee's effective date of coverage under the policy will be January 1st following the approved open enrollment period.

There is no guarantee that those employees, annuitants or dependents who were covered under the policy and voluntarily terminated their coverage will be allowed to re-enroll during an approved enrollment period. An annuitant who is terminated for non-payment mid-year may not be allowed to reenroll.

A late enrollee must apply using an approved application form and pay the required premium for single or family coverage. Benefits are subject to any applicable waiting periods or limitation.

If the late enrollee is an eligible employee, the eligible employee must be actively at work with the policyholder on his or her effective date of coverage under the policy. However, if an otherwise eligible employee is not actively at work on the date his or her coverage would otherwise become effective under the policy, his or her coverage, including limited family or family coverage for his or her eligible dependents if he or she enrolled such persons, shall not become effective until the earliest later date he or she is eligible and is actively at work with the policyholder.

Subsection I. Late Enrollees does not apply if you have a qualifying event as specified in subsection L. Qualifying Event.

I. Return from a Leave of Absence

A covered employee may continue coverage when not actively at work due to sickness, injury, leave of absence or temporary layoff. Coverage will be deemed to continue until terminated by discontinuance of premium payments or written request.

Coverage continued during a leave of absence in which the employee ceases to render services but continues to receive earnings and for which there has been no formal termination of the employer-employee relationship, will continue for the period of time specified according to Wisconsin Statutes Section 40.02(40).

Coverage continued during an approved unpaid leave of absence or temporary layoff may not be continued beyond 18 months from the last day for which the covered employee was paid, except for military leaves of absence or union leaves, for which insurance may be continued for the duration of the leave.

If an employee resumes employment after an absence during which premiums were not paid and no

coverage was in effect, he or she may re-enroll within 30 days of return to active work. Coverage will be effective on the first of the month on or following receipt of an approved application. Family coverage will be available if such coverage was in force prior to the employee's leave of absence.

J. Transfer of Coverage between Employees/Annuitants

Spouses and subscribers who are both eligible employees for this plan may have two single plans or one may carry a limited family or family contract. If one of the employees terminates employment or goes on a leave of absence the covered employees may:

- combine two single plans into one limited family; or
- split a limited family contract into two single contracts; or
- change which spouse is considered to be the covered employee under a family contract.

The change in coverage is effective on the first of the month on or after the employer's receipt of the application.

If an eligible employee's or dependent's effective date of regular coverage is deferred under A. or B. of this Section due to that person being confined, totally disabled or not actively at work, in some cases temporary coverage may nevertheless be provided to the minimum extent required by Section 6.51 (7) (b), Wis. Admin. Code, as amended.

K. Additional Changes in Coverage

All additional changes in coverage shall be determined by the policyholder based on the Administration Manual of the State of Wisconsin.

IV. BENEFITS

A. Payment of Benefits

1. Subject to the applicable annual deductible amount shown in Section 1. of the Schedule of Benefits if applicable as stated in Section 3., we'll pay benefits at the applicable coinsurance percentage shown in Section 3. of the Schedule of Benefits for charges for covered expenses described in B. below for dental services provided to a member in connection with preventive care or treatment of a covered illness or injury up to the applicable maximum benefit limits shown in Section 2. of the Schedule of Benefits.

All dental services must be dentally necessary and are subject to: (a) any deductible, coinsurance, waiting periods, maximum benefit limits and other limitations shown in the Schedule of Benefits; and (b) all other terms, conditions and provisions of the policy, including, but not limited to, alternate treatment as stated in paragraph 3. below.

The dental services must be ordered by a dentist or physician for preventive care or because of a covered illness or injury. If the term "NOT APPLICABLE" is shown in the Schedule of Benefits for a dental service or if the dental service is not listed in the Schedule of Benefits, that dental service is not covered and benefits are not payable for that dental service under the policy. Covered dental services must be provided while the member is covered under the policy.

The member is responsible for any amount of the charge for which benefits are not paid and for any amount that exceeds our determination of the charge for the dental service. The applicable deductible must be satisfied for the calendar year in which the covered expense is incurred before benefits are payable, unless specifically stated otherwise in the policy.

2. A member must submit, or have his/her dentist or physician submit, a written treatment plan to us in advance of treatment when amounts to be billed for a proposed covered dental service or series of proposed covered dental services would exceed $200. The treatment plan must be submitted prior to a dentist or physician performing any such dental services. If a member does not timely submit a treatment plan to us, we may decide that the dental service is not dentally necessary and no benefits will be paid for the dental service or any related dental service. Please see subsection B. of Section IX. Pre-Authorization.

3. If alternate treatment using other dental services may be employed to treat a member's illness or injury, covered expenses shall be limited to alternate treatment consisting of those dental services which are: (a) customarily employed in the treatment of the member's illness or injury covered under the policy and are recognized by the dental profession in the United States to be appropriate methods of treatment for the member's illness or injury in accordance with generally-accepted national standards of dental practice; and (b) accomplish the desired dental result in the most economical manner when taking into account the total current oral condition of the member who is the patient; as determined by us.

B. Covered Expenses

The following dental services are covered expenses. All dental services must be dentally necessary. All dental services must be ordered by a dentist or physician for preventive care or because of a covered illness or injury. If the dental service is not listed in this subsection, that dental service is not covered and benefits are not payable under the policy.

1. Preventive Services.

Subject to the deductible if applicable as shown in Section 3., we'll pay benefits for charges for the following dental services incurred by each member at the coinsurance percentage shown in Section 3.a. of the Schedule of Benefits subject to the maximum benefit limit shown in Section 2.a. of the Schedule of Benefits.

a. Routine oral exam, including diagnosis, at six month intervals.

b. Prophylaxis, including cleaning, scaling and polishing of teeth, at six month intervals.

c. Topical application of fluoride for a dependent child to age 16 who is a member. Benefits are limited to one application per 12-month interval.

d. Emergency palliative treatment for the relief of pain.

e. Complete series or Panorex x-rays. Benefits are limited to one complete series or panorex in any 60-consecutive-month interval.

f. Individual periapical x-rays.

g. Occlusal x-rays.

h. Extraoral x-rays. Benefits are limited to one film during a six month interval.

i. Bite-wing x-rays. Benefits are limited to one set per 12-month interval.

j. Sealants. Benefits for sealants are only available to a dependent child to age 16 who is a member. Benefits are limited to one application to a member's posterior permanent teeth per 18-month interval.

2. Basic Services.

Subject to the deductible if applicable as shown in Section 3., we'll pay benefits for charges for the following dental services incurred by each member at the coinsurance percentage shown in Section 3. b. of the Schedule of Benefits subject to the maximum benefit limit shown in Section 2. a. of the Schedule of Benefits.

a. Laboratory tests and other diagnostic examinations.

b. Oral surgery.

c. Anesthesia. Benefits are payable for the charge for general anesthesia billed as a separate procedure only when required for extraction of impacted teeth.

d. Routine and surgical extractions.

e. Therapeutic injections.

f. Periodontics, unless shown in Section 3. b. of the Schedule of Benefits as not applicable.

Periodontics, including all diagnoses, surgery and adjunctive services. Benefits for periodontic appliances are limited to one appliance per member in any 36-consecutive-month interval. Periodontal maintenance, either periodontal maintenance or adult prophylaxis at six month intervals.

g. Endodontics, unless shown in Section 3. b. of the Schedule of Benefits as not applicable.

h. Restorations, including fillings of amalgam or synthetic process, but specifically excluding the following: (1) posterior or anterior crowns or jackets; and (2) initial placement of full or partial dentures and replacements of dentures and fixed bridge units. Benefits for fillings of synthetic resin on posterior teeth shall be limited to the amount payable for fillings of amalgam.

i. Alveolectomy.

j. Denture repair and bridge work repair. Please see Section IX. General Exclusions.

k. Stainless steel crowns.

l. Space maintainers. Benefits for space maintainers are only available to a dependent child who is a member. Benefits are payable for charges for all adjustments provided to the member within six consecutive months of the space maintainer's installation.

3. Major Services.

Subject to the deductible if applicable as shown in Section 3., we'll pay benefits for charges for the following dental services incurred by each member at the coinsurance percentage shown in Section 3. c. of the Schedule of Benefits up to the maximum benefit limit shown in Section 2. a. of the Schedule of Benefits, unless shown in Section 3. c. of the Schedule of Benefits as not applicable.

a. Implants, inlays and onlays. Benefits are payable only when a tooth cannot be restored by an amalgam filling.

b. Crowns, other than stainless steel crowns. Benefits are payable only if a tooth cannot be restored by an amalgam filling or by other means. Crowns are not covered if placed for the purpose of periodontal splinting.

c. Periodontics, unless shown in Section 3. c. of the Schedule of Benefits as not applicable.

Periodontics, including all diagnoses, surgery and adjunctive services. Benefits for periodontic appliances are limited to one appliance per member in any 36-consecutive-month interval. Periodontal maintenance, either periodontal maintenance or adult prophylaxis at six month intervals.

d. Endodontics, unless shown in Section 3. c. of the Schedule of Benefits as not applicable.

e. Prosthetics, including bridges and dentures. Benefits are limited to the following:

(1) the initial installation of, or addition to, a full or partial denture or fixed bridgework, provided all of the following are met:

(a) that such installation or addition is required as a result of an extraction of one or more injured or diseased natural teeth on or after the member's effective date of coverage under the policy;

(b) that such installation or addition referred to in a. above includes the replacement of such an extracted tooth; and

(c) that such denture or bridgework is completed within 12 months following the date of the extraction, while that member is covered under the policy.

A denture or bridgework shall be considered initially installed only if such denture or bridgework does not replace the member's existing denture or bridgework.

(2) the replacement or alteration of a full or partial denture, fixed bridgework, crown, implants, inlay or onlay, provided the dentally necessary replacement or alteration:

(a) occurred on or after the member's effective date of coverage under the policy;

(b) cannot be satisfactorily repaired and restored to reasonable function, as determined by us; and

(c) is completed within 12 months and while the member is covered under the policy at such time after one of the following has occurred:

(i) an injury which requires surgical treatment; or

(ii) oral surgical treatment which involves the reposition of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue.

(3) the replacement of a full or partial denture, crown, implants, inlay or onlay when the replacement is required as a result of structural change within the mouth, provided all of the following are met, and the member is covered under the policy at such time:

(a) such replacement is done more than five years after the date of the installation of such denture, crown, implants, inlay or onlay; and

(b) any such replacement shall in no event be done less than two years after the member's effective date of coverage under the policy.

(4) the replacement of a full or partial denture, crown, implants, inlay or onlay other than as stated in (2) and (3) above only after 5 years have passed since the last such service was performed and the member is covered under the policy at such time. Such denture, crown, implants, inlay or onlay must not be satisfactorily repairable or restorable to reasonable function, as determined by us.

4. Orthodontia Services.

Subject to the deductible if applicable as shown in Section 3., we'll pay benefits for charges for the following dental services at the coinsurance percentage shown in Section 3. d. of the Schedule of Benefits, up to the maximum benefit limit shown in Section 2. b. of the Schedule of Benefits. However, if the words "NOT APPLICABLE" are shown in Section 3. d. of the Schedule of Benefits, the following are not covered under the policy. These benefits shall apply to only those members shown as being applicable in Section 3. d. of the Schedule of Benefits.

a. orthodontic appliances, includes furnishing and attachment of any necessary orthodontic appliances.

b. orthodontic treatment performed pursuant to a written treatment plan, including any supporting x-rays, submitted to us within 90 days prior to the commencement of such treatment.

Benefits are payable for charges for covered expenses incurred for any one course of orthodontic treatment, including any orthodontic diagnosis, evaluation and pre-orthodontic treatment.

V. DEDUCTIBLE AMOUNTS

A. Annual Deductible Amount

1. Annual Deductible Amount for Dental Services Directly Provided to a Member by a Preferred Provider.

The annual deductible amounts for both single and family coverage are shown in Section 1. a. the Schedule of Benefits. The appropriate deductible amount applies to each member each calendar year if shown in Section 3. as being applicable. If applicable, charges for covered expenses for dental services directly provided to you by a preferred provider must add up to the appropriate deductible amount before we pay benefits for other charges for covered expenses. No benefits are payable for charges used to satisfy the appropriate annual deductible amount and coinsurance amounts. You are responsible for paying the charges used to satisfy the appropriate deductible and coinsurance amounts. After the deductible amount for that coverage is satisfied, we'll pay benefits at the coinsurance percentage shown in Section 3. of the Schedule of Benefits for charges for the covered expenses incurred by that member, subject to the maximum benefit limits.

Charges for covered expenses for dental services applied by us to satisfy the annual deductible amount stated in paragraph 2. will also be used to satisfy this annual deductible amount.

2. Annual Deductible Amount for Dental Services Directly Provided to a Member by a Provider Other Than a Preferred Provider.

The annual deductible amounts for both single and family coverage are shown in Section 1. b. the Schedule of Benefits. The appropriate deductible amount applies to each member each

calendar year if shown in Section 3. as being applicable. If applicable, charges for covered expenses for dental services directly provided to you by a provider other than a preferred provider must add up to the appropriate deductible amount before we pay benefits for other charges for covered expenses. No benefits are payable for charges used to satisfy the appropriate annual deductible amount and coinsurance amounts. You are responsible for paying the charges used to satisfy the appropriate deductible and coinsurance amounts. After the deductible amount for that coverage is satisfied, we'll pay benefits at the coinsurance percentage shown in Section 3. of the Schedule of Benefits for charges for the covered expenses incurred by that member, subject to the maximum benefit limits.

Charges for covered expenses for dental services applied by us to satisfy the annual deductible amount stated in paragraph 1. will also be used to satisfy this annual deductible amount.

B. Lifetime Orthodontia Deductible Amount

1. Lifetime Orthodontia Deductible for Orthodontia Services Directly Provided to a Member by a Preferred Provider.

The lifetime orthodontia deductible amount is shown in Section 1. c. the Schedule of Benefits. The deductible amount applies to each member if shown in Section 3. d. as being applicable. If applicable, charges for covered expenses for orthodontia services directly provided to you by a preferred provider must add up to the deductible amount before we pay benefits for other charges for orthodontia services. No benefits are payable for charges used to satisfy the orthodontia deductible amount and coinsurance amounts. You are responsible for paying the charges used to satisfy the orthodontia deductible and coinsurance amounts. After the deductible amount is satisfied, we'll pay benefits at the coinsurance percentage shown in Section 3. d. of the Schedule of Benefits for charges for the covered orthodontia services incurred by that member, subject to the lifetime maximum benefit limit shown in Section 2. b. of the Schedule of Benefits. This deductible applies only to orthodontia services shown in Section V. B. 4. of the policy.

Charges for covered expenses for orthodontia services applied by us to satisfy the lifetime deductible amount stated in paragraph 2. will also be used to satisfy this lifetime deductible amount.

2. Lifetime Orthodontia Deductible for Orthodontia Services Directly Provided to a Member by a Provider Other Than a Preferred Provider.

The lifetime orthodontia deductible amount is shown in Section 1. d. the Schedule of Benefits. The deductible amount applies to each member if shown in Section 3. d. as being applicable. If applicable, charges for covered expenses for orthodontia services directly provided to you by a provider other than a preferred provider must add up to the deductible amount before we pay benefits for other charges for orthodontia services. No benefits are payable for charges used to satisfy the orthodontia deductible amount and coinsurance amounts. You are responsible for paying the charges used to satisfy the orthodontia deductible and coinsurance amounts. After the deductible amount is satisfied, we'll pay benefits at the coinsurance percentage shown in Section 3. d. of the Schedule of Benefits for charges for the covered orthodontia services incurred by that member, subject to the lifetime maximum benefit limit shown in Section 2. b. of the Schedule of

Benefits. This deductible applies only to orthodontia services shown in Section V. B. 4. of the policy.

Charges for covered expenses for orthodontia services applied by us to satisfy the lifetime deductible amount stated in paragraph 1. will also be used to satisfy this lifetime deductible amount.

VI. MAXIMUM BENEFIT LIMITS

A. Annual Maximum Benefit Limit

The annual maximum benefit limit is shown in Section 2. a. of the Schedule of Benefits. The maximum benefit limit applies to those dental services shown in Section 2. a. of the Schedule of Benefits and incurred by each member each calendar year.

B. Orthodontia Lifetime Maximum Benefit Limit

The orthodontia lifetime maximum benefit limit for Orthodontia Services is shown in Section 2. b. of the Schedule of Benefits. The orthodontia lifetime maximum benefit limit for Orthodontia Services applies to those dental services incurred by each member for the life of the policy, including renewals, while the member is covered under the policy.

VII. WAITING PERIODS

This section applies if shown in Section 4. of the Schedule of Benefits as being applicable.

The waiting period for the applicable dental services is the number of months shown in the Schedule of Benefits starting on the member's effective date of coverage under the policy. No benefits are payable for charges for dental services provided to the member, or for expenses incurred by that member, during the waiting period for the applicable dental services. Charges for covered expenses which are incurred for the applicable dental services provided to the member after the expiration of the waiting period for the applicable dental services, are eligible for benefits under the policy, subject to all limitations shown in the Schedule of Benefits and all terms, conditions and provisions of the policy. If a dependent child is born or is legally adopted by the covered employee or annuitant while he/she has family coverage under the policy the child doesn't have a waiting period.

VIII. GENERAL EXCLUSIONS

The following aren't covered under the policy. The policy provides no benefits for:

A. Dental services for any illness or injury arising out of, or in the course of, any activity for pay, profit or gain. This exclusion applies regardless of whether benefits under worker's compensation or similar laws have been claimed, paid, waived or compromised or whether you're covered under worker's compensation insurance.

B. Dental services furnished by the U.S. Veterans Administration, except for such dental services for which under applicable federal law the policy is the primary payor and the U. S. Veterans Administration is the secondary payor.

C. Dental services furnished by any federal or state agency or a local political subdivision when the member is not liable for the costs in the absence of insurance, unless coverage is required by any state or federal law.

D. Dental services for any injury or illness caused by: (1) atomic or thermonuclear explosion or resulting radiation; or (2) any type of military action, friendly or hostile.

E. Dental services for cosmetic purposes, unless necessitated as a result of injuries sustained while the member is covered under the policy.

F. Dental services which aren't dentally necessary or which aren't appropriate to the treatment of an illness or injury as determined by us.

G Dental services provided by members of a member's immediate family or anyone else living with him/her.

H. Dental services which are experimental or investigative.

I. Dental services not specifically identified as being covered under the policy.

J. Dental services when not provided by a dentist, physician or a licensed dental professional performing a related service requested by a dentist or physician.

K. Dental services provided when a member's coverage was not effective under the policy. This includes care provided either prior to the member's effective date of coverage or after his/her coverage terminated under the policy. Please see Section XII. When Coverage Ends.

L. Dental services in connection with any illness or injury caused by a member's commission of, or attempt to commit, an assault, battery, felony, or act of aggression, insurrection, rebellion, participation in a riot or engaging in an illegal occupation.

M. Dental services for replacement of a lost or stolen prosthesis.

N. Dental services for oral hygiene, dietary, or plaque control instructions and programs.

O. Athletic mouth guards.

P. Any amount billed by a dentist, physician or licensed dental professional because of the patient's failure to appear for a scheduled appointment.

Q. Dental services received from the dental or medical department of any employer, union, employee benefit association, trustee, or for services of a dentist or clinic contracted for or by any such organization.

R. Dental services for dentures, crowns, inlays, onlays, bridgework or appliances for altering vertical dimensions.

S. Dental services for denture or bridgework adjustments provided to a member within six months of the placement of a denture or bridgework with that member.

T. That portion of the amount billed for a porcelain-veneer crown or pontic on or replacing a tooth or teeth posterior to the second bicuspid, which exceeds our determination of the charge for a full-cast metal crown or pontic.

U. Dental services for a temporary denture or bridge that, when combined with the charge for the permanent denture or bridge, exceeds the reasonable charge for the permanent denture or bridge.

V. Dental services provided, for, or in connection with, precision or semiprecision attachments, denture duplication or other customized attachments.

W. Drugs and medicines, other than injectable antibiotics administered by a dentist or physician as a result of dental treatment.

X. Orthodontia services except as specifically provided in Section V. B. 4.

Y. Dental services, or that portion thereof, for which the member has no legal obligation to pay.

Z. Dental services provided during any waiting periods.

AA. Dental services provided in connection with the treatment of the temporomandibular joint, except for oral surgical services.

BB. That portion of the amount billed for the dental service covered under the policy that exceeds our determination of the charge for such dental service.

CC. Orthodontia services for other than malocclusion of natural teeth.

DD. Crowns for the purpose of periodontal splinting.

IX. PRE-AUTHORIZATION

A. Experimental, Investigative or Not Dentally Necessary Dental Services

We do not pay benefits for dental services that are experimental, investigative or not dentally necessary, as determined by us. We know it is difficult for a member to determine whether any non-emergency dental service will be covered before starting treatment. The types of dental services that may fall into this category, but not limited to these, are:

1. New dental technology;

2. New surgical methods or techniques;

3. Acupuncture or similar methods.

4. Methods of treatment by diet.

A member may ask us whether or not a dental service will be covered and how much in benefits will be paid. If a dental service is pre-authorized in writing by us, no payment can be made unless the member's coverage is in effect at the time the dental service is provided to the member.

B. When Amounts to Be Billed For Proposed Dental Services Exceed $200

If the amounts to be billed for proposed dental services for the performance of a covered dental service, or a series of covered dental services can reasonably be expected to exceed $200 the member or his/her dentist or physician must submit a written treatment plan. We will then inform the member and his/her dentist or physician of the coverage provided for the proposed services. In the event benefits are pre-authorized by us and the proposed course of treatment is not completed within 6 months from the date of submission of the treatment plan to us, a new treatment plan must be submitted to us within 6 months of the previous pre-authorization from us.

If a member does not use this pre-authorization process as described in A. or B. above, we may decide that the dental service is either experimental, investigative or not dentally necessary. No payment can then be made for the dental service or any related dental service.

If a member or his/her dentist or physician disagrees with our decision, the member may appeal that decision by submitting to us documentation from the treating dentist or physician as to the dental value or effectiveness of the dental service. Please see Section XIII. N. Claim Review Procedures. The decision on the appeal made by us at that time will be final.

X. COORDINATION OF BENEFITS

A. Applicability

1. This section applies to this plan when a covered employee or annuitant or the covered employee's or annuitant’s covered dependent has dental care coverage under more than one plan. "Plan" and "this plan" are defined below.

2. If this section applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:

a. shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but

b. may be reduced when, under the order of benefit determination rules, another plan determines its benefits first. This reduction is described in subsection D. Effect on the Benefits of This Plan.

B. Definitions

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

When a plan provides benefits in the form of services, the reasonable cash value of each service provided shall be considered both an allowable expense and a benefit paid.

2. **Claim Determination Period:** a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan or any part of a year before the date this COB provision or a similar provision takes effect.

3. **Plan:** any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

a. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

b. Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.

c. Medical expense benefits coverage in group, group-type, and individual automobile "no-fault" contracts, but as to the traditional automobile "fault" contracts, only the medical benefits written on a group or group-type basis are included.

Each contract or other arrangement for coverage under a., b. or c. is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

4. **Primary Plan/Secondary Plan:** Subsection C. Order of Benefit Determination Rules states whether this plan is a primary plan or secondary plan as to another plan covering the person.

When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, this plan may be a primary plan as to one or more other plans and may be a secondary plan as to a different plan or plans.

5. **This Plan:** the part of the policy that provides benefits for dental care expenses.

C. Order of Benefit Determination Rules

1. General.

When there is a basis for a claim under this plan and another plan, this plan is a secondary plan which has its benefits determined after those of the other plan, unless:

a. the other plan is other than automobile medical expense benefit coverage and has rules coordinating its benefits with those of this plan; and

b. both those rules and this plan's rules described in subsection C. 2. require that this plan's benefits be determined before those of the other plan. 2.Rules.

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

a. **Medical or Health Policy.** The benefits of a medical or health policy which covers the person on whose benefits claim is based shall be determined before the benefits of the policy.

b. **Non-dependent/Dependent.** The benefits of the plan which covers the person as an employee, member or insured are determined before those of the plan which covers the person as a dependent of an employee, member or insured.

c. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in subsection C. 2. d., when this plan and another plan cover the same child as a dependent of different persons, called "parents":

(1) the benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in that calendar year; but

(2) if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rules described in (1) but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan shall determine the order of benefits.

d. **Dependent Child/Separated or Divorced Parents.** If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) first, the plan of the parent with custody of the child;

(2) then, the plan of the spouse of the parent with custody of the child; and

(3) finally, the plan of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's dental care expenses or if the court decree states that both parents shall be responsible for the dental care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to C. 2. c.

However, if the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

e. **Active/Inactive Employee.** The benefits of a plan which covers a person as an employee who is neither laid-off nor retired or as that employee's dependent are determined before those of a plan which covers that person as a laid-off or retired employee or as that employee's dependent. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule e. is ignored. If a dependent is a Medicare beneficiary and if, under the Social Security Act of 1965 as amended, Medicare is secondary to the plan covering the person as a dependent of an active employee, the federal Medicare regulations shall supersede this paragraph e.

f. **Continuation Coverage.**

(1) If a person has continuation coverage under federal or state law and is also covered under another plan, the following shall determine the order of benefits:

(a) first, the benefits of a plan covering the person as an employee, member or insured or as a dependent of an employee, member or insured.

(b) second, the benefits under the continuation coverage.

(2) If the other plan does not have the rule described in subparagraph (1), and if, as a result, the plans do not agree on the order of benefits, this paragraph f. is ignored.

g. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or insured longer are determined before those of the plan which covered that person for the shorter time.

D. Effect on the Benefits of This Plan

1. When This Subsection Applies.

This subsection applies when, in accordance with subsection C. Order of Benefit Determination Rules, this plan is a secondary plan as to one or more other plans. In that event the benefits of this plan may be reduced under this subsection. Such other plan or plans are referred to as "the other plans" in 2. below.

2. Reduction in This Plan's Benefits.

The benefits of this plan will be reduced when the sum of the following exceeds the allowable expenses in a claim determination period:

a. the benefits that would be payable for the allowable expenses under this plan in the absence of this COB provision; and

b. the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made. Under this provision, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

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

E. Right to Receive and Release Needed Information

EPIC has the right to decide which facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the member but only as needed to apply these COB rules. Medical records remain confidential as provided by state law. Each person claiming benefits under this plan must give EPIC any facts it needs to pay the claim.

F. Facility of Payment

A payment made under another plan may include an amount which should have been paid under this plan. If it does, EPIC may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this plan. EPIC will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery

If the amount of the payments paid by us is more than we should have paid under this COB provision, we may recover the excess from one or more of the following:

1. the person(s) we have paid or for whom we have paid;

2. insurance companies; or

3. other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

XI. WHEN COVERAGE ENDS

As determined by us, your coverage under the policy shall end automatically without notice on the earliest of the following dates:

A. The date the policy terminates.

B. The day immediately following the last day of the calendar month in which the covered employee or annuitant dies. Any remaining premium credit balance due to an annuitant shall be made to the beneficiary according to the standard sequence established by Wis. Stat. 40.02 (8)(a).

C. The day immediately following the last day of the calendar month for which you remain eligible for the benefit as determined by your employer.

D. The day immediately following the last day of the calendar month in which a covered employee retires or loses eligibility, as determined by your employer, provided premium is paid. For annuitant, this means the last day of the calendar month in which the annuitant was covered as an active employee and paid any required premium. The covered employee may be eligible to continue coverage upon retirement under a separate benefit plan of the policy as determined by the covered employee's or annuitant's employer.

E. For a covered employee's or annuitant's dependent who is a member, the date the covered employee's or annuitant's coverage terminates.

F. For a covered employee's or annuitant's spouse who is a memberthe last day of the calendar month the covered employee's or annuitant's spouse is no longer married to the covered employee or annuitant due to divorce or annulment.

G. For a dependent child who is a member, the earliest of the following dates:

1. The day immediately following the last day of the calendar month the child reaches age 26;

2. The day immediately following the last day of the calendar month in which the adult child ceases to be a full-time student, if covered under military provision, as defined in the policy; or

3. For step-children, the last day of the calendar month the covered employee's or annuitant's spouse is no longer married to the covered employee or annuitant.

H. For a child of a dependent child who is a member, the last day of the calendar month the dependent child

reaches age 18.

I. The day immediately following the last day of the calendar month in which a member voluntarily terminates, as determined by your employer, his or her coverage.

J. The last day of the calendar month you enter into military service, other than for duty of less than 30 days, unless you provide copies of your order for active military status and provide applicable premium for coverage under the policy.

If the covered employee or annuitant has family coverage under the policy, a dependent child who is intellectually or physically disabled may continue coverage under the covered employee's or annuitant's family coverage beyond age 26 as set forth in the definition of "Dependent" in Section II. DEFINITIONS.

If a dependent has attained the limiting age while covered under the policy and continues coverage as a full-time student, he or she may continue coverage under the policy provided he or she ceases to be a full-time student due to a medically necessary leave of absence. In order to continue coverage, we must receive written documentation and certification of the medical necessity of the leave of absence from his or her attending physician. The date on which he or she ceases to be a full-time student due to the medically necessary leave of absence shall be the date on which coverage continuation begins.

Coverage shall continue for that full-time student until the earliest of the following dates:

1. He or she advises us that he or she does not intend to return to school full-time;

2. He or she becomes employed full time;

3. He or she obtains other health care coverage;

4. He or she marries and is eligible for coverage under his or her spouse's health coverage;

5. The date coverage of the subscriber through whom he or she has dependent coverage under the policy is discontinued or not renewed; or

6. One year following the date his or her continuation coverage began and he or she has not returned to school on a full-time basis.

XII. CONTINUATION OF COVERAGE

A. Wisconsin Law

In certain cases you may be eligible to continue your terminated coverage which would otherwise end under Section XI. WHEN COVERAGE ENDS in accordance with Section 632.897, Wisconsin Statutes, as amended. Those eligible for continuation coverage are: (1) a covered employee or annuitant who is no longer eligible for coverage under the policy through the policyholder, except if his or her employment is terminated for misconduct; or (2) a covered

employee's or annuitant's spouse or dependent who is no longer eligible for coverage under the policy through the policyholder due to divorce, annulment or death of the covered employee or annuitant. In either case, you must be covered under the policy through the policyholder for at least three months immediately prior to the termination date of your coverage.

Within five days of the policyholder's receiving notice to end your coverage or notice that you are eligible under (1) or (2) above, the policyholder must notify you of:

1. Your option to continue your coverage under this subsection;

2. The premium amount you must pay monthly to continue your coverage subject to subsection C. Premium Reduction Provision. The premium amount for continuation coverage will be at the premium rate that we require for such coverage.

3. The manner in which and the place to which you must make premium payments; and

4. The time by which you must pay the premiums required for continuation coverage.

If you are eligible to purchase continuation coverage under Section 632.897, Wisconsin Statutes, and timely elect to continue your coverage and pay to the policyholder the required premium within 30 days after receiving the notice described above from the policyholder, the policyholder must notify us of your election of continuation coverage as soon as reasonably possible in the manner required by us. Your continuation coverage under the policy may be continued until the earliest of the following dates:

1. The date you become eligible for other similar group health care coverage or the same coverage under the policy;

2. For a covered employee's or annuitant's spouse, the date the covered employee or annuitant is no longer eligible for coverage under the policy;

3. The date the policy terminates;

4. The end of the last coverage period for which you paid the required premium; or

5. The end of 18 consecutive months after you elect continuation coverage.

If any of the five events described above applies to a member with continuation coverage, the member whose continuation coverage terminated under the policy due to that event must give written notice of that event to the policyholder and us as soon as reasonably possible.

Continuation of coverage also allows:

1. An annuitant and his/her dependent(s) may continue coverage indefinitely.

2. A surviving spouse of a deceased employee may continue coverage indefinitely.

3. A surviving dependent child of a deceased employee may continue coverage until they

otherwise lose eligibility.

4. An ex-spouse due to divorce or annulment may continue coverage for up to 36 months, or until the children otherwise lose eligibility.

B. Federal Law

A member who is no longer eligible for coverage under the policy, such as a member whose employment ends with the policyholder, certain dependent children, or a divorced or surviving spouse and his or her children, may be eligible for continuation coverage in accordance with the Federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), as amended.

Members must contact the policyholder within 60 days of a divorce or a child losing dependent status under the policy in order to be eligible for COBRA continuation. The member has 60 days following the termination date to elect to continue coverage under COBRA.

If the member is eligible to purchase continuation coverage under COBRA, please see the policyholder for further information.

XIII. GENERAL PROVISIONS

A. Your Relationship With Your Dentist, Physician, Licensed Dental Professional or Other Health Care Provider

We won't interfere with the professional relationship you have with your dentist, physician, licensed dental professional or other health care provider. We don't contract with you to choose or provide a dentist, physician, licensed dental professional or other health care provider or services or facilities; nor do we assure their availability. We're not responsible for any injury, damage or expense (including attorneys' fees) you suffer as a result of any improper advice, action or omission on the part of any dentist, physician, licensed dental professional or other health care provider. We're obligated only to provide the benefits as specifically stated in the policy.

B. Dentist, Physician, Licensed Dental Professional or Other Health Care Provider Reports

Dentists, physicians, licensed dental professional or other health care providers must give us their records and reports to help us determine benefits due to you. By accepting coverage under the policy you agree to authorize your dentists, physicians, licensed dental professionals and other health care providers to release all dental records and reports to us for yourself and all your dependents. This is a condition of our providing coverage to you and all your dependents. It's also a continuing condition of our paying benefits. You expressly authorize and direct any provider who has diagnosed for, attended, treated, advised or provided dental services to you to release such records and reports to us. You authorize them to furnish to us any and all information related to the dental services, supplies or facilities provided to or used by you, to the extent required by a particular situation and allowed by applicable law. You also expressly authorize us to release to or obtain from any other insurance

company or service or benefit plan the information which we need for us to determine our liability to pay benefits under the policy.

C. Other EPIC Coverage

You may have coverage under the policy and other medical or dental coverage under either: (1) a similar EPIC individual or group policy; or (2) extended benefits payable for you under a prior EPIC individual or group health policy. If so, benefits paid under all EPIC policies combined shall not exceed 100% of the total charges for covered expenses incurred by you while you are insured under those EPIC policies.

D. Assignment of Benefits

This coverage is just for a covered employee or annuitant and his/her covered dependents. Benefits may be assigned to the extent allowed by Wisconsin insurance law.

E. Subrogation

Each member agrees that we shall be subrogated to all of the member's rights to the extent of the benefits we provide under the policy. Those rights are hereby assigned to us to that extent. The assigned rights include, but are not limited to, rights against: (1) all persons or organizations, and their insurers, liable or responsible for paying for losses or damages sustained by the member; (2) automobile liability insurance coverage; (3) underinsured motorists insurance coverage; (4) uninsured motorists insurance coverage; (5) homeowner liability insurance coverage; (6) medical malpractice insurance coverage; (7) patient compensation funds; and (8) any applicable umbrella insurance coverage. The assigned rights shall not be reduced or diminished under any circumstances by attorney's fees, court cost or any other costs of collection which may be incurred by the member.

We have no right to recover from a member if he/she has not been made whole, after taking into consideration his/her comparative negligence. If a dispute arises between us and the member over the question of whether or not the member has been made whole, we have the right to a judicial determination of whether the member has been made whole. Such a determination shall be governed by the rules of evidence, shall require the fact finder to determine the dollar amount that makes the member whole, and in all other substantive and procedural respects shall be conducted as is any other civil jury trial.

Each member shall promptly advise us in writing whenever a claim against any person and/or organization is made on behalf of the member and shall further provide to us such additional information as is reasonably requested by us. The member agrees to fully corporate in protecting our rights against any person and/or organization. A member shall not enter into a settlement or compromise arrangement with any person and/or organization without our prior written consent. Entering into any such settlement or arrangement is a breach of this contract; such a breach shall be deemed to prejudice our rights.

F. Limitation on Lawsuits and Legal Proceedings

No member shall bring any legal action against us regarding benefits, claims submitted, to compel our payment of benefits or any other matter concerning his/her coverage under the policy until the earlier of: (1) 60 days after we've received or waived proof of claim described in subsection H. Proof of Claim below; or (2) the date we deny payment of benefits for a claim. Action can be brought earlier if waiting will result in prejudice against a member. However, the mere fact that a member has to wait until the earlier of the above is not considered prejudicial. No action can be brought more than three years after the time we require written proof of claim. Please see subsection H. Proof of Claim below.

G. Severability

Any terms, conditions or provisions of the contract which may be prohibited by Wisconsin law shall be void and be without force or effect. But this won't invalidate the enforceability of any other term, condition or provision of the contract.

H. Proof of Claim

You, or the dentist, physician, licensed dental professional or other health care provider on your behalf, must submit written proof of your claim for each dental service provided to you to us within 120 days of the date on which you receive that dental service. Written proof of your claim includes: (1) the completed claim forms if required by us; (2) the actual itemized bill for each dental service; and (3) all other information that we need to determine our liability to pay benefits under the policy, including, but not limited to, records and reports. We may require as part of the proof of claim a complete dental chart showing any extractions, fillings, or other work performed prior to the date of the loss for which claim is being made; itemized bills of the dentist or other sources of service, supplies and treatment; x-rays, laboratory or hospital reports, casts, molds, or study models, or other similar evidence of the condition or treatment of the teeth and oral cavity. Circumstances beyond your control might prevent you from submitting such proof to us within this time period. If so, you must file written proof of your claim with us as soon as possible; but it can't be later than one year and 120 days after the occurrence, unless you are legally incapacitated as determined by a court of law during this entire period. If we don’t receive the written proof of claim required by us within that one-year and 120-day period and you are not legally incapacitated, no benefits are payable for that dental service covered under the policy.

I. Conformity With Laws of the State of Wisconsin

On the effective date of the policy, any term, condition or provision conflicting with the laws of the State of Wisconsin applying to the policy automatically conforms with the minimum requirements of such laws.

J. Entire Contract Changes

The entire contract between you and us is made up of the p, including the policyholder's signed Contract by Authorized Board, , the certificate, Schedule of Benefits, all endorsements, if any, your application, and your supplemental applications, if any,

K. Waiver and Change

Only our Chief Executive Officer can execute a waiver or make a change to the policy. No agent, broker or other person may waive or change any term, condition, exclusion, limitation, or other provision of the policy in any way or extend the time for any premium payment. At our option, EPIC may unilaterally change any term, condition, exclusion, limitation, or other provision of the policy if we send written notice to the policyholder at least 30 days in advance of that change. When the change reduces coverage provided under the policy, we must send written notice of the change to the policyholder at least 60 days before any such change takes effect. Any change to the policy shall be made by endorsement which is signed by our Chief Executive Officer. Each endorsement shall be binding on the policyholder, each of its members, and EPIC. No error by EPIC, the policyholder, or any member shall invalidate coverage otherwise validly in force, continue or reissue coverage validly terminated, or cause coverage to be issued which otherwise would not be issued by EPIC. Upon our discovery of any error, an equitable adjustment of coverage, payment of benefits, and/or premium shall be made by EPIC at its sole option.

L. Limit on Certain Defenses

After two years have passed from your effective date of coverage under the policy, no misstatements will be used to void your coverage or deny benefits for any claim beginning after the two-year period expires. This doesn't apply to fraudulent misstatements made in your application or any supplemental applications.

M. Direct Payments and Recovery

1. Direct Payment of Benefits.

Unless otherwise specifically stated in the policy, we have the option of paying benefits either directly to the dentist, physician, hospital or other health care provider, or to you as described in Section XII. N. Claims Processing Procedure below. Payments for covered expenses for which we're liable may be paid under another group or franchise plan or policy arranged through your employer, trustee, union or association. If so, we can discharge our liability by paying the organization that has made these payments. In either case, such payments shall fully discharge us from all further liability to the extent of benefits paid.

2. Recovery of Excess Payments.

If we pay more benefits than what we're liable to pay for under the policy, including, but not limited to, benefits paid in error by us, we can recover such excess benefit payments from any person, organization, dentist, physician, hospital or other health care provider that has received

such excess benefit payments. We can also recover such excess benefit payments from any other insurance company, service plan or benefit plan that has received such excess benefit payments. If we cannot recover such excess benefit payments from any other source, we can also recover such excess benefit payments from you. When we request that you pay us an amount of the excess benefit payments, you agree to pay such amount immediately upon our notification to you. We may, at our option, reduce any future benefit payments for which we are liable under the policy on other claims by the amount of the excess benefit payments, in order to recover such payments. We will reduce such benefits otherwise payable for such claims until the excess benefit payments are recovered by us.

N. Claims Processing Procedure

1. Definitions.

Correctly filed claim: a claim that includes: (a) the completed claim forms if required by us; (b) the actual itemized bill for each dental care service; and (c) all other information that we need to determine our liability to pay benefits under the policy, including but not limited to, dental records and reports.

Incomplete claim: a correctly filed claim that requires additional information including, but not limited to, medical information, coordination of benefits questionnaire, subrogation questionnaire.

Incorrectly filed claim: claim that is filed that lacks information which enables us to determine what, if any, benefits are payable under the terms and conditions of the policy. Examples would include, but are not limited to, claims filed that are missing procedure codes, diagnosis or dates of service.

2. Procedures.

Benefits payable under the policy will be paid within 30 days after receipt of a correctly filed claim. EPIC will notify you of its decision on your claim as follows:

If the claim is an incomplete claim or incorrectly filed claim, we may notify you of a 15 day extension and the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information. Once we have received the additional information, we will make our decision within the period of time equal to the 15-day extension in addition to the number of days remaining from the initial 30-day period. For example, if our notification was sent to you on the fifth day of the first 30-day period, we would have a total of 40 days to make a decision on your claim following the receipt of the additional information. Under no circumstances will the period for making a final determination on your claim exceed 90 days from the date we received the post-service claim.

If benefits are payable on charges for services covered under the policy, we'll pay such benefits directly to the provider providing such services, unless you have already paid the charges and submitted paid receipts therefor to us before we pay benefits. We will send you written notice of

the benefits we paid on your behalf. If you have already paid the charges and are seeking reimbursement from us, payment of such benefits will be made directly to you.

If the claim is denied in whole or in part, you will receive a written notice from us with: (1) the specific reason(s) on which denial or partial denial is based; and (2) an explanation of how you may have the claim reviewed by us if you do not agree with our denial or partial denial. Please see subsection entitled AClaim Review Procedures@ below.

O. Grievance Procedure

Situations might occasionally arise when you, as a member, question or are unhappy with a claims decision made by us or some aspect of our policy administration, claims processing, or service that you received from us. Since most of these situations can be informally resolved by us, please contact us. We will try to resolve your complaint by talking to your vision care provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file a grievance.

"Grievance" means any dissatisfaction with the provision of services or claims practices of an insurer offering a dental benefit plan or administration of a dental benefit plan by the insurer that is expressed in writing to the insurer by or on behalf of, a member.

You, or someone on your behalf, may file the grievance. The grievance must:

1. Be in writing; and

2. Provide pertinent information such as your customer identification number, patient's name, date, and place of service, and reason for requesting the review. If the grievance is not claim related, please include a description of the problem and the resolution you are looking for.

The grievance should be sent to the following address:

Grievance/Appeal Committee
The EPIC Life Insurance Company
P. O. Box 8430
Madison, Wisconsin 53708
Fax Number: (608) 223-2159

It will be helpful if you identify your letter as a grievance. We will acknowledge the grievance within five business days of receiving it. We will examine all relevant facts including any materials or records that you submit. You may appear in person before the grievance committee to:

1. Present written or oral information; and

2. Question the persons responsible for making the decision that resulted in the grievance.

We will notify you of the time and place of the committee meeting at least seven calendar days before the meeting.

After review, we will provide a written decision, including reasons, within 30 calendar days of receiving the grievance. If special circumstances require a longer review period, we will provide our written decision within 60 calendar days of receiving the grievance. If we need the extra days, we will notify you of the reason why, and when a decision may be expected.

P. Filing an Expedited Grievance

In certain circumstances, you may request that we review your grievance within 72 hours. You may do this if the standard grievance resolution process would include any of the following:

1. Serious jeopardy to your life or health or your ability to regain maximum function;

2. A situation where, in the opinion of a physician with knowledge of your medical condition, you would be subjected to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance; or

3. A situation where, in the opinion of a physician with knowledge of your medical condition, that you must receive the treatment that is the subject of the grievance right away.

You may file an expedited grievance via a phone call to us. You must provide the pertinent information listed above. We will resolve the expedited grievance within 72 hours of receiving it.

You may resolve your problem by taking the steps outlined above. You may also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's Insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSION OF INSURANCE** by writing to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, Wisconsin 53707-7873

or you can call 1-800-236-8517 outside of Madison or 266-0103 in Madison, and request a complaint form.