



The Lincoln National Life Insurance Company
A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066
(800) 423-2765 Online: www.LincolnFinancial.com

CERTIFIES THAT Group Policy No. 00001D0 [REDACTED] has been issued to

[REDACTED]

(The Group Policyholder)

The issue date of the Policy is September 1, 2018.

The insurance is effective only if the Employee is eligible for insurance and becomes and remains insured as provided in the Group Policy.

Certificate of Insurance for Class 1

If you have elected Dependent coverage, your Dependents are covered under this Certificate only if you have completed the section on your enrollment form and the required premium has been paid.

You are entitled to the benefits described in this Certificate only if you are eligible, become and remain insured under the provisions of the Policy. This Certificate replaces any other certificates for the benefits described inside. As a Certificate of Insurance, it is not a contract of insurance; it only summarizes the provisions of the Policy and is subject to the Policy's terms. If the provisions of this Certificate and the Policy do not agree, the provisions of the Policy will apply.

PRESIDENT

**CERTIFICATE OF GROUP
DENTAL INSURANCE**

TOLL-FREE TELEPHONE NUMBERS FOR INFORMATION AND COMPLAINTS

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call The Lincoln National Life Insurance Company's toll-free telephone number for information or to make a complaint at:
1-800-423-2765.

You may also write to The Lincoln National Life Insurance Company at:
Group Insurance Service Office
8801 Indian Hills Drive
Omaha, Nebraska 68114-4066

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:
1-800-252-3439.

You may write the Texas Department of Insurance:
P.O. Box #149104
Austin, TX 78714-9104
FAX: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de The Lincoln National Life Insurance Company's para obtener información o para presentar una queja al:
1-800-423-2765.

Usted también puede escribir a The Lincoln National Life Insurance Company:
Group Insurance Service Office
8801 Indian Hills Drive
Omaha, Nebraska 68114-4066

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:
1-800-252-3439.

Usted puede escribir al Departamento de Seguros de Texas a:
P.O. Box #149104
Austin, TX 78714-9104
FAX: (512) 490-1007
Sitio Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:

Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA: Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

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SCHEDULE OF BENEFITS

ELIGIBLE CLASS

Class 1 All Full-Time Employees Electing the Low Plan

CONTRACTING DENTIST PLAN.

Outside Texas – Dental Preferred Provider Organization (PPO) Plan

This Contracting Dentist Plan is designed to provide high quality dental care while managing the cost of the care. To do this, you are encouraged to seek dental care from Dentists who have signed a contract with the dental panel being offered by the Policy. These Dentists are called Contracting Dentists.

Use of a Contracting Dentist is voluntary. You may receive treatment from any Dentist you choose. And you are free to change Dentists at any time. But, your out-of-pocket expenses for covered services are usually lower when the services are provided by a Contracting Dentist, though the Policy does not guarantee reduced expenses. Regardless of the Dentist you choose, benefits will be based on the terms, conditions and limitations of the Policy. In Texas, the same Percent Payable, Deductible(s) and Maximums must be used for a Non-Contracting Dentist as those for a Contracting Dentist.

A Directory of Contracting Dentists is available from your Employer. Information about Contracting Dentists is included on your ID card. When you enroll Eligible Dependents, two ID cards will be provided.

When using a Contracting Dentist, you must present the ID Card. Most Contracting Dentists prepare the necessary claim forms, and submit them to the Company for you. Benefits are based on the terms of the Policy.

OPEN ENROLLMENT PERIOD: There will be an Open Enrollment Period not to exceed a 60 day period each year, for eligible Employees and their Dependents to enroll for Dental Insurance. Late Entrant Limitations will be waived for anyone enrolling during this Open Enrollment Period. Dental Insurance will become effective on the September 1st following the Open Enrollment period.

[REDACTED]
00001D0 [REDACTED]
SCHEDULE OF BENEFITS

**For
Class 1 - All Full-Time Employees Electing the Low Plan**

MINIMUM HOURS: 20 hours per week

ELIGIBILITY WAITING PERIOD: (For date insurance begins, refer to "Effective Date" section)
None

Contributions: You are required to contribute to the cost for Employee Dental Coverage and Dependent Dental Coverage.

Benefit Waiting Period:

Type 2 Procedures: None
Type 3 Procedures: None
Type 4 Procedures: None

Prior Plan Credits: Terms of the Prior Plan Credit provision apply for persons covered on the issue date of the Policy. Refer to the Prior Plan Credit provision in the Policy.

Continuity of Coverage. Terms of the Continuity of Coverage provision apply to persons who were enrolled in another employer's group dental plan within 31 days before the Dental Expense Benefits under the Policy take effect. See the Continuity of Coverage provision of this Certificate.

Late Entrant Limitation (when applicable):

Type 2 Procedures: None
Type 3 Procedures: None
Type 4 Procedures: None



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**SCHEDULE OF BENEFITS
DENTAL BENEFITS**

**Contracting Dentist Non-Contracting
Dentist**

Calendar Year DEDUCTIBLE
for these Procedure Types (combined)
INDIVIDUAL
FAMILY

Types 2 & 3
\$50
\$150
Types 2 & 3
\$50
\$150

PERCENT PAYABLE
Type 1 - Diagnostic & Preventive Services
Type 2 - Basic Services
Type 3 - Major Services
Type 4 - Orthodontic Services for Dependent Children

90%
50%
50%
50%
90%
50%
50%
50%

Type 1, 2 and 3 Benefits Based On

Negotiated Fees
70th
Percentile of Usual
& Customary
Allowance

Calendar YEAR MAXIMUM
for these Procedure Types (combined)
The *MaxRewards*SM Benefit is included. Please refer to the "Rollover of Calendar Year Maximum" page.

\$1,500
Types 1, 2 & 3
\$1,500
Types 1, 2 & 3

LIFETIME MAXIMUM
for Type 4 Procedures – Orthodontics for Dependent Children

\$1,000
\$1,000

On the CLAIMS PROCEDURES page, the provision captioned "TO WHOM PAYABLE" is amended to read as follows.

TO WHOM PAYABLE. Dental Expense Benefits generally will be paid to the Covered Employee; unless the Covered Employee has assigned such benefits to the Dentist, or an overpayment has been made. However, if services are provided by a Contracting Dentist, benefits are automatically assigned to that Dentist, unless the bill has been paid.

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DEFINITIONS

ACTIVE WORK or ACTIVELY AT WORK means an Employee's full-time performance of all customary duties of his or her occupation at:

- (1) the Employer's place of business; or
- (2) any other business location designated by the Employer.

Unless disabled on the prior workday or on the day of absence, an Employee will be considered Actively at Work on the following days:

- (1) a Saturday, Sunday or holiday which is not a scheduled workday;
- (2) a paid vacation day, or other scheduled or unscheduled non-workday;
- (3) a non-medical leave of absence of 12 weeks or less, whether taken with the Employer's prior approval or on an emergency basis; or
- (4) a Military Leave or an approved Family or Medical Leave that is not due to the Employee's own health condition.

APPROPRIATE TREATMENT (includes **APPROPRIATE**) means the range of services and supplies by which a dental condition may be treated, which falls within the generally accepted practices of dentistry. Appropriate Treatment may vary in techniques, materials utilized and technical complexity, as well as cost.

BENEFIT WAITING PERIOD means the period of time a Covered Person must be covered for Dental Expense Benefits -- or for a specific type of Dental Expense Benefits -- under the Policy before that type of service becomes eligible for coverage.

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

CONTRACTING DENTIST means a Dentist who:

- (1) has signed a contract with the dental panel being made available through the Policy; and
- (2) has agreed to abide by the rules of that panel.

It is the Covered Employee's responsibility to verify whether the Dentist is a Contracting Dentist at the time of service. Contracting Dentists are independent contractors; they are not employees or agents of the panel or the Company. The Company does not supervise, control or guarantee the services of the Contracting Dentist or any other Dentist.

COVERAGE MONTH means that period of time:

- (1) beginning at 12:01 a.m. on the first day of any calendar month; and
- (2) ending at 12:00 midnight on the last day of the same calendar month;

at the Group Policyholder's primary place of business.

COVERED EMPLOYEE means an eligible Employee for whom the coverage provided by the Policy is in effect.

DEFINITIONS

COVERED EXPENSES means expenses Incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures contained in the Policy. Covered Expenses:

- (1) for a Contracting Dentist, do not exceed:
 - (a) the Dentist's normal charge for a procedure; or
 - (b) the fee allowed by the Dentist's contract with the dental panel; whichever is less; or
- (2) for a Non-Contracting Dentist's charges, do not exceed:
 - (a) for Type 1, 2 or 3 procedures, the Policy's Usual and Customary allowances; and
 - (b) for Type 4 procedures, the maximum Covered Expense, as determined by the Company.

These expenses must be Incurred for procedures performed by a Dentist or by a dental hygienist, under the direction of a Dentist. The expenses must be Incurred while covered by the Policy for those procedures for which a claim is being submitted. Covered Expenses are subject to the terms and limitations of the Policy.

COVERED PERSON means an eligible Employee or an eligible Dependent for whom the coverage provided by the Policy is in effect.

DAY OR DATE means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, at the Group Policyholder's place of business; when used with regard to eligibility dates and effective dates. When used with regard to termination dates, it means 12:00 midnight, at the same place.

DENTIST means a licensed doctor of dentistry, operating within the scope of his or her license, in the state in which he or she is licensed.

DEPENDENT: See the Eligibility for Dependent Dental Coverage section of the Policy.

DEPENDENT DENTAL COVERAGE means the coverage provided by the Policy for eligible Dependents.

ELIGIBILITY WAITING PERIOD means the continuous period of time that an Employee must be employed in an eligible class with the Group Policyholder, before he or she becomes eligible to enroll for coverage under the Policy.

This Eligibility Waiting Period may be waived for an Employee who qualifies for reinstatement of his or her coverage, as provided in the Policy.

EMPLOYEE means a Full-Time Employee of the Employer.

EMPLOYEE DENTAL COVERAGE means the coverage provided by the Policy for eligible Employees.

EMPLOYER means the Group Policyholder or the Participating Employer named on the Face Page.

EXPENSES INCURRED (includes **INCURRED**). An expense is Incurred at the time a service is rendered or a supply is furnished, except that an expense is considered Incurred:

- (1) for an appliance (or change to an appliance), at the time the impression is made;
- (2) for a crown or bridge, at the time the tooth or teeth are prepared; and
- (3) for root canal therapy, at the time the pulp chamber is opened;

provided the service is completed within 31 days from the date it is begun.

FAMILY OR MEDICAL LEAVE means an approved leave of absence that:

- (1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
- (2) is taken in accord with the Employer's leave policy and the law which applies; and
- (3) does not exceed the period approved by the Employer and required by that law.

DEFINITIONS (Continued)

The leave period, may:

- (1) consist of consecutive or intermittent work days; or
- (2) be granted on a part-time equivalency basis.

If an Employee is entitled to a leave under both the federal FMLA law and a similar state law, he or she may elect the more favorable leave (but not both). If an Employee is on an FMLA leave due to his or her own health condition on the date Policy coverage takes effect, he or she is not considered Actively at Work.

FULL-TIME EMPLOYEE means an employee of the Employer:

- (1) whose employment with the Employer is the employee's principal occupation;
- (2) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Benefits;
- (3) who is not a temporary or seasonal employee;
- (4) who is a member of an employee class which is eligible for coverage under the Policy; and
- (5) who is a citizen of the United States or who legally works in the United States.

GROUP POLICYHOLDER means the person, partnership, corporation, trust, or other organization, as shown on the Title Page of the Policy.

INJURY means damage to a Covered Person's mouth, teeth, appliance, or dental prosthesis due to an accident that occurs while he or she is covered by the Policy. Damage resulting from chewing or biting food or other objects is not considered to be an Injury.

LATE ENTRANT means an eligible Employee who makes written application:

- (1) more than 31 days after the Employee first becomes eligible for Employee Dental Coverage;
- (2) after Employee Dental Coverage has been cancelled; or
- (3) after Employee Dental Coverage has been terminated due to failure to pay premiums when due.

LATE ENTRANT also means an eligible Dependent for whom written application is made:

- (1) more than 31 days after he or she first qualifies for Dependent Dental Coverage;
- (2) after the Covered Employee has requested to terminate Dependent Dental Coverage; or
- (3) after Dependent Dental Coverage has been terminated due to failure to pay premiums when due.

Exception for involuntary loss of coverage under another group dental plan. A person will not be considered a Late Entrant if, due to the existence of coverage under an employer's group dental plan, the Employee and/or any Dependents did not enroll within 31 days of becoming eligible for coverage under the Policy; and coverage under the other plan ends for one of the following reasons:

- (1) termination of the other plan by the sponsoring employer;
- (2) loss of the Employee's eligibility in the other plan due to his or her termination of employment or a change in his or her employment classification;
- (3) loss of a spouse's eligibility under the other plan due to his or her termination of employment or a change in his or her employment classification; or
- (4) loss of the Employee's or a Dependent's eligibility under the other plan due to a divorce or the death of the spouse.

This exception will not apply if:

- (1) the loss of coverage under the other dental plan is voluntary (for example, voluntary termination of coverage based on premium contribution levels or the extent of benefits provided); or
- (2) a person enrolls for coverage under the Policy more than 31 days after becoming eligible following the loss of coverage continued under COBRA.

DEFINITIONS (Continued)

In order to qualify for this exception, each person applying for coverage under the Employer's dental plan must:

- (1) provide proof of coverage under the spouse's prior dental plan; and
- (2) enroll for coverage and pay premiums for the Employer's plan within 31 days following loss of coverage under the other dental plan.

LATE ENTRANT LIMITATION PERIOD means the period of time a Late Entrant must be covered for a specific type of Dental Expense Benefits under the Policy before that type of service becomes eligible for coverage.

MILITARY LEAVE means a leave of absence that:

- (1) is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
- (2) is taken in accord with the Employer's leave policy and the federal USERRA law; and
- (3) does not exceed the period required by that law.

NECESSARY DENTAL PROCEDURE (includes **NECESSARY** and **DENTAL NECESSITY**) means a procedure, service or supply which the Company, or a qualified party selected by the Company, determines is:

- (1) required by, and Adequate and Appropriate for the diagnosis or treatment of a dental disease, condition or injury;
- (2) Appropriate and consistent with the symptoms and findings, or with the diagnosis and treatment of the Covered Person's dental disease, condition or injury;
- (3) provided in accord with generally accepted practices of dentistry, consistent with current scientific evidence and clinical knowledge;
- (4) on the List of Covered Dental Procedures contained in the Policy;
- (5) the most Appropriate and Professionally Adequate level of service or supply which can be provided on a cost effective basis without adversely affecting the Covered Person's dental condition;
- (6) the least costly professionally acceptable type of service that will adequately treat the condition; and
- (7) not primarily for aesthetic purposes.

Necessary Dental Procedures include the Diagnostic and Preventive Services contained in the List of Covered Dental Procedures contained in the Policy.

The fact that a person's Dentist prescribes a service or supply does not automatically mean that such services or supplies are considered as Necessary Dental Procedures and are covered by the Policy.

NON-CONTRACTING DENTIST means a Dentist who is not contracting in the dental panel being made available through the Policy.

OPEN ENROLLMENT PERIOD means the period in the calendar year, not to exceed 60 days, during which the Group Policyholder allows eligible Employees to purchase or make changes in their Employee or Dependent Dental Coverage.

Participation in an Open Enrollment Period does not change Policy provisions related to the Eligibility Waiting Period or Benefit Waiting Periods.

DEFINITIONS

ORTHODONTIC TREATMENT means the use of active appliances to move and correct the position of maloccluded or malpositioned teeth. Orthodontic treatment includes:

- (1) the orthodontic treatment plan and all records;
- (2) the fabrication and insertion of fixed appliances;
- (3) periodic visits and ongoing treatment and adjustments; and
- (4) the retention phase, including periodic visits and passive appliances.

Orthodontic Treatment also includes x-rays, surgical and non-surgical procedures, anesthesia, and other services related to orthodontic care.

PAYROLL PERIOD means that period of time established by the Group Policyholder for payment of employee wages. A Payroll Period may be weekly, biweekly, semimonthly or monthly.

POLICY means this group dental policy issued by the Company to the Group Policyholder.

PROFESSIONALLY ADEQUATE (includes **ADEQUATE**) means the least expensive form of treatment, within the range of Appropriate Treatments, for a given dental condition, that conforms to the generally accepted practices of dentistry.

USUAL AND CUSTOMARY (U&C) means the maximum expense covered by the Policy. U&C allowances are based on dental charge information collected by nationally recognized industry databases. U&C allowances are reviewed and updated periodically.

If Covered Expenses are Incurred outside the United States, the U&C allowance will be the amount that would be allowed for that procedure if it had been performed at the Company's Group Insurance Service Office in Omaha, Nebraska.

U&C allowances may be higher or lower than the fees charged by a Dentist. U&C is not an indication of the appropriateness of the Dentist's fee. Instead, U&C is a variable plan provision used to determine the extent of coverage provided by the Policy.

YOU (includes **YOUR**) means an eligible Employee for whom the coverage provided by the Policy is in effect.

ELIGIBILITY AND EFFECTIVE DATES FOR EMPLOYEE DENTAL COVERAGE

ELIGIBILITY. You become eligible for the coverage provided by the Policy on the later of:

- (1) the Policy's date of issue; or
- (2) the date the Eligibility Waiting Period is completed.

The Eligibility Waiting Period is shown in the Schedule of Benefits.

EFFECTIVE DATE. Employee Dental Coverage becomes effective on the latest of:

- (1) the first day of the Coverage Month coinciding with or next following the date you become eligible for the coverage;
- (2) the date you resume Active Work, if not Actively at Work on the day you become eligible. You will be deemed Actively at Work on any regular non-working day, if you:
 - (a) are not totally disabled or hospital confined on that day; and
 - (b) were Actively at Work on the regular working day before that day;
- (3) if you contribute to the cost of the Employee Dental Coverage, the first day of the Coverage Month coinciding with or next following the date you make written application for coverage; and sign:
 - (a) a payroll deduction order, if you pay any part of the Policy premium for Employee Dental Coverage; or
 - (b) an order to pay premiums from your Section 125 Plan account, if any contributions are paid through a Section 125 Plan; and pay the first month's premium to the Company; or
- (4) the first day of the Coverage Month coinciding with or next following the date the Company approves a Late Entrant's application.

Any increase in coverage or benefits becomes effective at 12:01 a.m. on the latest of:

- (1) the first day of the Insurance Month coinciding with or next following the date on which you become eligible for the increase, if Actively at Work on that day; or
- (2) the day you resume Active Work, if not Actively at Work on the day the increase would otherwise take effect.

Any reduction in coverage or benefits will take effect on the day of the change, whether or not you are Actively at Work.

OPEN ENROLLMENT PERIOD. You again become eligible to enroll, re-enroll, or change benefit options for Employee Dental Coverage under the Policy during the Group Policyholder's Open Enrollment Period. Any unsatisfied Benefit Waiting Period(s) will apply to coverage elected or changed during the Open Enrollment Period. If you terminate coverage under the Policy and subsequently re-enrolls during an Open Enrollment Period, you will again be subject to the Policy's Benefit Waiting Period(s).

TERMINATION OF EMPLOYEE DENTAL COVERAGE

TERMINATION. Your coverage will terminate on the earliest of:

- (1) the date the Policy is terminated;
- (2) the last day of the Coverage Month in which you request termination;
- (3) the date through which premium has been paid on your behalf;
- (4) the last day of the Coverage Month in which you cease to be in a class of Employees which is eligible for coverage under the Policy;
- (5) with respect to a benefit for a specific type of dental service, the date the portion of the Policy providing benefits for that type of service terminates; or
- (6) the last day of the Coverage Month in which your employment with the Group Policyholder terminates.

CONTINUATION OF COVERAGE. Ceasing Active Work results in termination of coverage; but Employee and Dependent Dental Coverage may be continued as follows.

FAMILY OR MEDICAL LEAVE. If you go on an approved Family or Medical Leave and are **not** entitled to any more favorable continuation available during disability, then coverage may be continued until the earliest of:

- (1) the end of the leave period approved by the Employer;
- (2) the end of the leave period required by federal law, or any more favorable period required by a similar state law;
- (3) the date you notify the Employer that you will not return; or
- (4) the date you begin employment with another employer.

The required premium payments must be received from the Employer, throughout the period of continued coverage.

MILITARY LEAVE OF ABSENCE/TERMINATION OF EMPLOYMENT DUE TO MILITARY SERVICE. If you go on leave for military service of more than 30 days, Dental Coverage may be continued:

- (1) for up to 18 Coverage Months, if the leave begins prior to December 10, 2004; or
 - (2) for up to 24 Coverage Months, if the leave begins on or after December 10, 2004;
- subject to payment of premiums.

ELIGIBILITY FOR DEPENDENT DENTAL COVERAGE

DEPENDENT means a person who is your:

- (1) legal spouse, who is not legally separated from you;
- (2) unmarried child less than 26 years of age; or
- (3) unmarried child age 26 years or older, who is:
 - (a) continuously unable to earn a living because of a physical or mental disability;
and
 - (b) chiefly dependent upon you for support and maintenance.

The child must be covered by the Group Policyholder's dental plan on the day before coverage would otherwise end due to his or her age. Proof of the total disability must be sent to the Company:

- (a) within 31 days of the day coverage would otherwise end due to age; and
- (b) thereafter, when the Company requests (but not more than once every two years).

"Child" includes:

- (1) your natural child or legally adopted child;
- (2) a child placed with you for the purpose of adoption, from the date of placement;
- (3) a child for whom you are required by court order to provide dental coverage;
- (4) a stepchild who resides in your household; and who is chiefly dependent on you for support;
and
- (5) a grandchild who is dependent on you for federal income tax purposes at the time of application for coverage of the child; and
- (6) a foster child:
 - (a) who resides in your household;
 - (b) who is chiefly dependent on you for support; and
 - (c) for whom you have assumed full parental responsibility and control.

ELIGIBILITY. You become eligible to enroll for Dependent Dental Coverage on the latest of:

- (1) the date you become eligible for Employee Dental Coverage;
- (2) the issue date of the Policy; or
- (3) the date you first acquire a Dependent.

You must be covered for Employee Dental Coverage to cover your Dependents.

OPEN ENROLLMENT PERIOD. You again become eligible to enroll, re-enroll, or change benefit options for Dependent Dental Coverage under the Policy during the Group Policyholder's Open Enrollment Period. Any unsatisfied Benefit Waiting Period(s) will apply to coverage elected or changed during the Open Enrollment Period. If you terminate Dependent Dental Coverage under the Policy and subsequently re-enroll during an Open Enrollment Period, your Dependents will again be subject to the Policy's Benefit Waiting Period(s).

EFFECTIVE DATES FOR DEPENDENT DENTAL COVERAGE

EFFECTIVE DATES. Except as provided in the NEW DEPENDENTS section, Dependent Dental Coverage will become effective on the latest of:

- (1) the first day of the Coverage Month coinciding with or next following the date you become eligible for Dependent Dental Coverage;
- (2) the first day of the Coverage Month coinciding with or next following the date you make written application for Dependent Dental Coverage; and, if additional premium is required, you sign:
 - (a) a payroll deduction order, if you pay any part of the premium for Dependent Dental Coverage; or
 - (b) an order to pay premiums from the Employee's Section 125 Plan account, if any contributions for Dependent Dental Coverage are paid through a Section 125 Plan account;and pay the first month's Dependent premium to the Company; or
- (3) the first day of the Coverage Month coinciding with or next following the date the Company approves a Late Entrant application for each Dependent applying for Dependent Dental Coverage.

COURT ORDERED COVERAGE. If coverage is provided to a child based on a court order which requires you to provide dental benefits for the child, the coverage will become effective on the date stated in the court order; subject to payment of any additional premium.

NEW DEPENDENTS. If you acquire a new Dependent, coverage for the new Dependent will become effective on the date the Dependent is acquired; provided:

- (1) you complete a written application; and
- (2) if additional premium is required, a payroll deduction order or Section 125 Plan election is made and any additional premium is paid to the Company;

within 31 days of the date the Dependent is acquired.

EXCEPTION FOR NEWBORN. If you acquire a newborn Dependent child, the child will be automatically covered for the first 31 days following birth. If you elect not to enroll the newborn child and pay any additional premium within 31 days following birth, the newborn child's coverage will terminate.

However, any Benefit Waiting Period(s) and/or Late Entrant Limitation Periods will be waived for such Dependent child if you elect to enroll the child and pay the applicable premium at any time prior to or within 31 days following the child's third (3rd) birthday.

DENTAL EXPENSE BENEFITS

BENEFIT. The Company will pay Dental Expense Benefits if a Covered Person incurs Covered Expenses in excess of the Deductible during a Calendar Year. The Company will pay the Percentage Payable shown in the Schedule of Benefits for that type of service; provided any Benefit Waiting Period is satisfied. Benefits will be paid up to the Maximum shown in the Schedule of Benefits for each Covered Person.

BENEFIT DETERMINATION. The amount of benefits payable for Type 1, 2 and 3 Procedures will be determined as follows:

- (1) Dates of service are reviewed and categorized by:
 - (a) services prior to effective date;
 - (b) services after termination date; and
 - (c) covered services by benefit period or calendar year.
- (2) Each procedure, service or supply is evaluated to ensure that it qualifies as a Necessary Dental Procedure which is determined to be Professionally Adequate under the terms of the Policy.
- (3) Covered Expenses are determined, and are reduced by any unmet Deductible amount.
- (4) Then, each remaining expense for each covered service is multiplied by the Percent Payable for that type of service, to determine the Dental Expense Benefits payable, subject to Policy provisions, maximums, limitations and exclusions.

Benefits for Covered Expenses are based on Dental Necessity. Services which are determined to be not Necessary are not covered by this Policy, even if they are recommended or provided by a Dentist.

DEDUCTIBLE. The Deductible shown in the Schedule of Benefits is the amount of Covered Expenses which must be incurred before benefits are payable. The Deductible applies separately to the Covered Expenses Incurred by each Covered Person. Benefits will be based on those Covered Expenses which are in excess of the Deductible.

After Covered Expenses Incurred by all covered family members combined exceed the Family Deductible shown in the Schedule of Benefits, no additional Covered Expenses will be applied toward the Deductible in that Calendar Year.

BENEFIT WAITING PERIODS. The Benefit Waiting Periods are shown on the Schedule of Benefits pages of this Certificate.

LATE ENTRANT LIMITATION PERIODS. The Late Entrant Limitation Periods are shown on the Schedule of Benefits pages of this Certificate.

ALTERNATIVE PROCEDURES

There may be two or more methods of treating a dental condition. The amount of Covered Expense will be limited to the charge for the least costly procedure or treatment which:

- (1) the dental profession recognizes to be Professionally Adequate, in accord with generally accepted practices of dentistry; and
- (2) the Company determines to be both Adequate and Appropriate, in view of the Covered Person's total current oral condition.

To determine its liability for a dental procedure submitted for consideration, the Company may request the pre-operative dental x-rays and any other pertinent information. Based on its review of this information, the Company will decide which procedure would provide Professionally Adequate restoration, replacement or treatment.

The Covered Person may receive the more expensive procedure or treatment. However, the Company's liability for Covered Expense will be limited to the least expensive procedure which it determines to be Professionally Adequate care.

To find out in advance what charges or alternative procedures will be considered Covered Expenses, you may use the Dental Claim Procedure for Predetermination of Benefits, described in the Policy.

DENTAL EXPENSE BENEFITS ORTHODONTICS FOR CHILDREN

BENEFITS FOR TYPE 4 SERVICES. The Company will pay Dental Expense Benefits for Orthodontic Treatment if a covered Dependent Child:

- (1) begins Orthodontic Treatment while covered for Type 4 services (Orthodontics), under the Policy; and
- (2) incurs Covered Expenses for Orthodontic Treatment after any Benefit Waiting Period or Late Entrant Limitation Period is satisfied.

The Company will pay the Percentage Payable shown in the Schedule of Benefits for Type 4 services.

Benefits will be paid up to the Maximum shown in the Schedule of Benefits during the covered Dependent Child's lifetime; but only for Covered Expenses Incurred while covered under the Policy.

The Lifetime Maximum will be reduced, on a prorated basis, for orthodontic treatment received before the Dependent Child was covered for Type 4 services, including services received while the Dependent Child was in a Benefit Waiting Period or Late Entrant Limitation Period.

BENEFIT WAITING PERIOD. The Benefit Waiting Period for Type 4 services (Orthodontics) is shown on the Schedule of Benefits page. Benefits for Type 4 services begun before, or received during, this Benefit Waiting Period will not be payable.

LATE ENTRANT LIMITATION PERIOD. The Late Entrant Limitation Period for Type 4 services (Orthodontics) is shown on the Schedule of Benefits page. Benefits for Type 4 services begun before or received during this Late Entrant Limitation Period will not be payable.

BENEFIT PAYMENTS. Orthodontic Treatment is assumed to be provided in accord with a Treatment Plan.

- (1) Covered Expenses will be based upon the estimated cost and duration of the Treatment Plan; and
- (2) Benefit payments will be pro-rated over the expected duration of the Treatment Plan, as long as the Dependent Child remains covered by the orthodontic benefit provision of the Policy, subject to the Lifetime Maximum for Type 4 Procedures shown on the Schedule of Benefits.

TREATMENT PLAN means a related series of orthodontic services prescribed by a Dentist to correct a specific dental condition.

PREDETERMINATION OF BENEFITS. To find out in advance what benefits will be payable for orthodontic treatment, see the Dental Claims Procedure for Predetermination of Benefits.

LIMITATIONS AND EXCLUSIONS

Except as required by law, Covered Expenses will not include, and Dental Expense Benefits will not be payable, for:

- (1) any procedure begun:
 - (a) before you or your Dependent were covered under the Policy, subject to the Prior Plan Credit provision and the Continuity of Coverage Provision, if included in the Policy; or
 - (b) after termination of your or your Dependent's coverage under the Policy.
- (2) treatment or service which:
 - (a) is not recommended by a Dentist or is not provided by or under the direct supervision of a Dentist;
 - (b) is not a Necessary Dental Procedure, required for the care and treatment of a dental condition, as determined by the Company;
 - (c) is not specifically listed as covered by the Policy;
 - (d) does not meet generally accepted practices of dentistry; or
 - (e) is provided by a physician or other health care provider, but is beyond the scope of his or her license.
- (3) charges which exceed Covered Expenses, as defined in the Policy. Benefits will not be payable when:
 - (a) total benefit payments would exceed the Annual or Lifetime Maximums payable under the Policy; or
 - (b) services exceed the frequency limitations contained on the List of Covered Dental Procedures in the Policy.
- (4) procedures which are subject to Benefit Waiting Periods or Late Entrant Limitation Periods, until those Benefit Waiting Periods or Late Entrant Limitation Periods have been satisfied.
- (5) Orthodontic (Type 4) services:
 - (a) which begin before your Dependent child becomes covered under the Policy for orthodontic services, subject to the Prior Plan Credit provision and the Continuity of Coverage Provision, if included in the Policy;
 - (b) which begin during a Benefit Waiting Period or a Late Entrant Limitation Period, subject to the Prior Plan Credit provision and the Continuity of Coverage Provision, if included in the Policy;
 - (c) received after your Dependent child's coverage ends, due to attainment of the maximum age, or for any other reason; or
 - (d) received after coverage for Type 4 services is terminated under the Policy.
- (6) any treatment or services which:
 - (a) are for mainly cosmetic purposes (including but not limited to bleaching of teeth; veneers; and porcelain, composite, or resin-based restorations or prosthetics for posterior teeth, except as specifically shown in the List of Covered Dental Procedures included in the Policy); or
 - (b) are related to the repair or replacement of any prior cosmetic procedure.
- (7) services related to the replacement of third molars (wisdom teeth).

LIMITATIONS AND EXCLUSIONS

- (8) except as specifically shown in the List of Covered Dental Procedures included in the Policy, any procedure associated with the placement, restoration, or removal of a dental implant, and any related expenses. Related expenses may include but are not limited to:
 - (a) periodontal services which would not have been performed if the implant had not been planned and/or installed; and
 - (b) any resulting increase in charges for services covered by the Policy that are related to the dental implant.
- (9) any procedure related to a dental disease or Injury to natural teeth or bones of the jaw that is considered a covered service under any group medical plan.
- (10) orthognathic recording, orthognathic surgery, osteoplasty, osteotomy, LeFort procedures, stomatoplasty, computed tomography imaging (CT scans), cone beam, or magnetic resonance imaging (MRIs).
- (11) the adjustment, recementation, relin, rebase, replacement or repair of cast restorations, crowns and prostheses, within 6 months of the completion of the service.
- (12) the replacement of any major restorative services—including, but not limited to, crowns, inlays, onlays, bridges, and dentures—within the time periods shown in the List of Covered Dental Procedures from the date of the last placement of these items. If a replacement is required because of an accidental dental Injury sustained while you or your Dependent is covered under the Policy, it will be a Covered Expense. If services related to the Injury are covered by your or your Dependent's group medical plan, those charges should be submitted to the medical plan first.
- (13) specialized procedures, including:
 - (a) precision or semi-precision attachments;
 - (b) precious metals for removable appliances;
 - (c) overlays and overdentures; or
 - (d) personalization or characterization.
- (14) duplicate prosthetics or appliances, or for initial placement or replacement of athletic mouth guards, night guards; and, except as specifically included in the List of Covered Dental Procedures contained in the Policy, bruxism appliances or any appliance to correct harmful habits; and for replacement of:
 - (a) space maintainers; or
 - (b) broken, misplaced, lost or stolen dental appliances.
- (15) appliances, restorations or procedures, or their modifications, that:
 - (a) alter vertical dimension;
 - (b) restore or maintain occlusion or for occlusal adjustment or equilibration;
 - (c) stabilize teeth;
 - (d) replace tooth structure lost as a result of erosion, abfraction, abrasion or attrition;
 - (e) surgically or non-surgically treat disturbances of the temporomandibular joint (TMJ), or other craniomandibular or temporomandibular disorders, except as required by law or as specifically shown in the List of Covered Dental Procedures; or
 - (f) involve elimination of undercuts, box form, or concave irregularity caused in the preparation.

LIMITATIONS AND EXCLUSIONS

- (16) charges for services provided by:
 - (a) an ambulatory surgical facility;
 - (b) a hospital;
 - (c) any other facility; or
 - (d) an anesthesiologist.
- (17) except as specifically shown in the List of Covered Dental Procedures included in the Policy, analgesia, sedation, hypnosis or acupuncture, for anxiety or apprehension.
- (18) any medications administered outside the Dentist's office or for prescription drugs.
- (19) except as specifically shown in the List of Covered Dental Procedures included in the Policy, charges which do not directly provide for the diagnosis or treatment of a dental Injury or condition, such as:
 - (a) the completion of claim forms;
 - (b) broken appointments;
 - (c) interest or collection charges;
 - (d) sales taxes, except where required by law, or other taxes or surcharges;
 - (e) education, training and supplies used for dietary or nutritional counseling, personal oral hygiene or dental plaque control;
 - (f) caries susceptibility tests, bacteriologic studies, oral cancer screenings, histopathologic exams or pulp vitality testing;
 - (g) copying of x-rays or other dental records; or
 - (h) duplication of services.
- (20) itemized or separated charges for dental services, supplies or materials when those services, supplies and materials may be combined into a single, more comprehensive procedure payable under the Policy. This also includes itemized charges which are routinely included in the Dentist's charge for the primary service, such as:
 - (a) sterilization or asepsis charges;
 - (b) a charge for local anesthesia or analgesia, including nitrous oxide;
 - (c) charges for pre- and post-operative care;
 - (d) temporary or provisional dental services (for example, a temporary crown), which are considered to be part of the permanent service, except for interim dentures to replace teeth extracted while covered by the Policy.
- (21) charges for which you are not liable, or which would not have been made had no coverage been in force.
- (22) your or your Dependent's dental Injury or condition:
 - (a) for which you or your Dependent is eligible for benefits under Workers' Compensation or any similar law;
 - (b) arising out of, or in the course of, work for wage or profit; or
 - (c) sustained while performing military service.
- (23) services received for dental conditions caused directly or indirectly by:
 - (a) war or an act of war;
 - (b) intentionally self-inflicted Injury;
 - (c) engaging in an illegal occupation;
 - (d) commission or attempt to commit a felony; or
 - (e) your or your Dependent's active participation in a riot.

LIMITATIONS AND EXCLUSIONS

- (24) scaling and root planing, or other periodontal treatment; unless x-rays and pocket depth charting for each tooth confirm that the bone and attachment loss establish Dental Necessity for treatment.

SPECIMEN

COORDINATION OF DENTAL EXPENSE BENEFITS

EFFECT ON BENEFITS. If you or your Dependent is covered by another Plan, the Dental Expense Benefits under the Policy and benefits under the other Plan(s) will be coordinated for the Claim Period. The Order of Benefit Determination Rules on the next page decide which Plan pays first.

- (1) **Primary Benefits.** When this Plan must pay its full benefits first, the Dental Expense Benefits under this Certificate will be paid as if the other coverage did not exist.
- (2) **Secondary Benefits.** When another Plan must pay its full benefits first, the Dental Expense Benefits under this Certificate:
 - (a) will be calculated as if the other coverage did not exist; and then
 - (b) will be reduced so that total benefits, from all Plans combined, will not exceed 100% of the Allowable Expenses incurred by the Claimant during that Claim Period.

Benefits will be coordinated with any benefit amounts that would be payable for the Allowable Expenses under the other Plan(s), whether or not claim is actually made. When this Plan's benefits are reduced, each benefit is reduced in proportion. Then, the reduced benefit payments are applied towards the Maximums of this Plan.

DEFINITIONS. The following definitions apply only to this coordination provision.

"**Plan**" means any group insurance or group type coverages (whether insured or uninsured), which provide medical or dental care benefits or services. This includes but is not limited to:

- (1) Blue Cross and Blue Shield plans;
- (2) blanket (other than school accident coverage) and franchise insurance plans;
- (3) Health Maintenance Organization (HMO) and Dental Maintenance Organization (DMO) plans; and
- (4) other prepayment, group practice and individual practice plans.

It also includes any coverage under a government medical or dental plan required or provided by law; except Medicaid. This Plan must pay its benefits before Medicaid pays. Coordination with Medicare will be in accord with federal law.

Each of the above coverages is a separate Plan. If an arrangement has two or more parts, and its coordination provision applies only to some benefits or services; then each part is a separate plan.

"**Allowable Expense**" means any necessary, Usual and Customary expense for dental care, which is at least partly covered under at least one of the Plans covering the Claimant. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered during the Claim Period will be considered Allowable Expense.

"**Claimant**" means you or your Dependent for whom claim is made.

"**Claim Period**" means a calendar year (or part of a calendar year) during which the Claimant has been covered under the Policy.

ORDER OF BENEFIT DETERMINATION RULES. To decide which Plan pays first, the Company will use the first of the following rules which applies.

- (1) **Noncoordinated/Coordinated Plan.** A Plan without a coordination provision will pay its benefits before a Plan which includes a coordination provision.
- (2) **Nondependent/Dependent.** A Plan covering the Claimant as an employee, member or subscriber will pay its benefits before a Plan covering the Claimant as a dependent.
- (3) **Child of Parents Not Separated or Divorced.** If the Claimant is a dependent child whose parents **are not** separated or divorced, the Plan of the parent whose birthday falls earlier in the calendar year will pay first. However:
 - (a) if both parents have the same birthday, the Plan which has covered the parent longer will pay first; and
 - (b) if the Plan coordinates benefits based upon the sex of the parents, the male parent's plan will pay first.
- (4) **Child of Separated or Divorced Parents.** If the Claimant is a dependent child whose parents **are** separated or divorced, then:
 - (a) the Plan of the parent who is required by court decree to pay the child's dental expenses will pay first;
 - (b) provided the Plan receives notice of the court decree before paying or providing benefits.

If there is no notice of a court decree requiring payment of such expense, then:

- (a) the custodial parent's Plan pays first;
- (b) the Plan of the custodial parent's spouse pays next (if the custodial parent is remarried); and
- (c) the noncustodial parent's Plan pays last.

When a noncustodial parent is responsible for the Claimant's dental expenses, benefits may be paid directly to the provider, if the custodial parent requests this.

- (5) **Active/Inactive Employee.** A Plan covering the Claimant as a laid off or retired employee (or a dependent of such an employee) will pay after a Plan covering the Claimant on some other basis; provided the other Plan:
 - (a) includes this coordination rule for laid off or retired employees; or
 - (b) is issued in a state which requires this rule by law.A Plan covering the Claimant pursuant to federal COBRA Continuation law will pay after a Plan covering the Claimant as an employee (or a dependent of an employee).
- (6) **Length of Coverage.** If none of the above rules apply, then the Plan which has covered the Claimant longer will pay first.

RIGHT TO EXCHANGE DATA. To determine the benefits payable under this section, the Company has the right to exchange information with any insurance company, organization or person. Such data may be exchanged without the consent of (or any notice to) you or your Dependent. When you claim benefits under the Policy, you must provide the Company with the data required to apply this Section.

PAYMENT AND OVERPAYMENT. Other Plans may make payments which this Plan should have made in accord with this Section. In that event, the Company has the right to reimburse any amount it deems necessary to satisfy the intent of this Section. If the Company pays such benefits to an organization in good faith, it will not be liable to the extent of the payment.

The Company also has the right to recover any overpayment it makes because of coverage under another Plan. The Company may recover the amounts needed to satisfy the intent of this Section from any insurance company, organization or person to or for whom Policy benefits were paid.

SPECIMEN

CLAIM PROCEDURES FOR DENTAL COVERAGE

NOTICE AND PROOF OF CLAIM

Notice of Claim. Written notice of claim must be given within 20 days after a dental claim is incurred; or as soon as reasonably possible after that.* The notice must be sent to the Company's Group Insurance Service Office. It should include:

- (1) the Group Policyholder's (or Participating Employer's) name and Policy number;
- (2) your name, address and certificate number, if available; and
- (3) the patient's name and relationship to you.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days; then you may send the Company written proof of claim in a letter. It should state the nature, date and cause of the claim.

Proof of Claim. The Company must be given written proof of claim within 90 days after the date of services; or as soon as reasonably possible after that.* Proof of claim must be provided at your own expense. It must include:

- (1) the nature, date and cause of the claim;
- (2) a description of the services provided and the Dentist's charges for those services; and
- (3) a signed authorization for the Company to obtain more information.

Within 15 days after receiving the first proof of claim, the Company may send a written acknowledgment. It will request any missing information or additional items needed to support the claim. This may include:

- (1) any study models, treatment records or charts;
- (2) copies of any x-rays or other diagnostic materials; and
- (3) any other items the Company may reasonably require.

*** Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim; if it is shown that it was done:

- (1) as soon as reasonably possible; and
- (2) in no event more than one year after it was required.

These time limits will not apply while the claimant lacks legal capacity.

PHYSICAL EXAMS. While a dental claim is pending, the Company may have you or your covered Dependent examined:

- (1) by a Physician or Dentist of its choice;
- (2) as often as is reasonably required.

Any such exam will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any Dental Expense Benefits payable under the Policy will be paid:

- (1) immediately after the Company receives complete proof of claim and confirms liability; and
- (2) in any event, within 60 days after the Company receives acceptable proof of claim.

TO WHOM PAYABLE. Dental Expense Benefits will be paid to you; unless:

- (1) benefits have been assigned;
- (2) an overpayment has been made and the Company is entitled to reduce future benefits; or
- (3) state or federal law requires that benefits be paid to:
 - (a) your covered Dependent child's custodial parent or custodian; or
 - (b) the provider, due to that parent's or custodian's assignment.

CLAIM PROCEDURES (Continued)

Exception: Dental Expense Benefits will be paid to the Texas Department of Human Resources (the Department), if:

- (1) the Department incurs expense for your or your covered Dependent's dental treatment; and
- (2) the provider of services affixes a notice of this on the claims submitted.

This payment will not exceed the actual expense incurred by the Department.

NOTICE OF CLAIM DECISION. The Company will send you a written notice of its claim decision. If the Company denies any part of the claim; then the written notice will explain:

- (1) the reason for the denial, under the terms of this Policy and any internal guidelines;
- (2) how you may obtain a clinical explanation, upon request and without charge; when benefits are:
 - (a) denied because the service is not considered a Necessary Dental Procedure; or
 - (b) reduced in accord with the Alternative Procedures provision;
- (3) how you may request a review of the Company's decision; and
- (4) whether any more information is needed to support the claim.

This notice will be sent within 15 days after the Company resolves the claim. It will be sent within 30 days after the Company receives the first proof of claim, if reasonably possible.

Delay Notice. If the Company needs more time to process a claim, in a special case; then an extension will be permitted. In that event, the Company will send you a written delay notice:

- (1) by the 15th day after receiving the first proof of claim; and
- (2) every 30 days after that, until the claim is resolved.

The notice will explain:

- (1) the special circumstances which require the delay;
- (2) whether any more information is needed to decide the claim; and
- (3) when a decision can be expected.

If you do not receive a written decision within 45 days after the Company receives the first proof of claim; then there is a right to an immediate review, as if the claim was denied.

Exception: If the Company needs more information from you to process a claim; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. Within 180 days after receiving a denial notice, you may request a claim review by sending the Company:

- (1) a written request; and
- (2) any written comments or other items to support the claim.

You may review certain non-privileged information relating to the request for review.

The Company will review the claim and send you a written notice of its decision. The notice will:

- (1) explain the reasons for the Company's decision, under the terms of the Policy and any internal guidelines;
- (2) offer to provide a clinical explanation, upon request and without charge; when benefits have been:
 - (a) denied because the service is not considered a Necessary Dental Procedure; or
 - (b) reduced in accord with the Alternative Procedures provision;
- (3) describe any further appeal procedures available under the Policy; and
- (4) describe your right to access relevant claim information and to bring legal action.

CLAIM PROCEDURES
(Continued)

The notice will be sent within 30 days after receiving the request for review.

Exception: If the Company needs more information from you to process an appeal; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limit for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, you must first seek two internal reviews of the adverse claim decision, in accord with the above provision. If you are an ERISA claimant and bring legal action under Section 502(a) of ERISA after the required review; then the Company will waive any right to assert that you failed to exhaust administrative remedies.

RIGHT OF RECOVERY. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

- (1) reduce future benefits until full reimbursement is made; and
- (2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to:

- (1) the Company's error in processing a claim;
- (2) the claimant's receipt of benefits or services under another plan;
- (3) fraud or any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

DENTAL CLAIM PROCEDURE
for
PREDETERMINATION OF BENEFITS

If a Covered Person is advised to have non-emergency dental treatment which will cost \$300 or more, he or she should find out in advance what charges may be considered Covered Expenses under the Policy.

To use this procedure:

- (1) you should request a claim form and take it to the Dentist;
- (2) the Dentist will list the proposed procedures and fees on the claim form and return it to the Company along with x-rays and diagnostic aids necessary to verify the need for the procedure; and
- (3) the Company will verify current eligibility and determine what benefits would be payable for the procedures listed.

SPECIMEN

DENTAL COVERAGE CONTINUATION

The following provisions comply with the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. These provisions apply when Dental Coverage is provided by a private Employer with 20 or more employees (as defined by COBRA). Any further changes made to the COBRA continuation requirements will automatically apply to these continuation provisions.

RIGHT TO CONTINUE. Insurance may be continued in accord with the following provisions when:

- (1) a Covered Person becomes ineligible for Policy coverage due to a Qualifying Event shown below; and
- (2) the Policy remains in force.

"Qualifying Event," as it applies to you, means your termination of employment, hours reduction or retirement, if it would otherwise result in a Qualified COBRA Beneficiary's loss of Policy coverage.

"Qualifying Event," as it applies to your Covered Dependent, means one of the following events, if it would otherwise result in a Qualified COBRA Beneficiary's loss of Policy coverage:

- (1) your termination of employment, retirement or hours reduction;
- (2) your death, divorce or legal separation;
- (3) your becoming entitled to Medicare benefits; or
- (4) your child's ceasing to be an eligible Covered Dependent, under the terms of the Policy.

"Qualified Beneficiary" means you and your Covered Dependent who is entitled to continue insurance under the Policy, from the date of your first Qualifying Event. It also includes your natural child, legally adopted child or child placed for the purpose of adoption; when the new child:

- (1) is acquired during your 18- or 29-month continuation period; and
- (2) is enrolled for insurance in accord with the terms of the Policy.

But it does **not** include your new spouse, stepchild or foster child acquired during that continuation period; whether or not the new Dependent is enrolled for Policy coverage.

CONTINUATION PERIODS. The maximum period of continued coverage for each Qualifying Event shall be as follows.

Termination of Employment. When eligibility ends due to your termination of employment; then coverage for you and your Covered Dependents may be continued for up to 18 months, from the date employment ended. Termination of employment includes a reduction in hours or retirement. **Exceptions:**

- (1) **Misconduct.** If your termination of employment is for gross misconduct, coverage may **not** be continued for you or your Covered Dependents.
- (2) **Disability.** "Disability" or "Disabled" as used in this section, shall be as defined by Title II or XVI of the Social Security Act and determined by the Social Security Administration.

If you:

- (a) become disabled by the 60th day after your employment ends; and
 - (b) are covered for Social Security Disability Income benefits;
- then coverage for you and your Covered Dependents may be continued for up to 29 months, from the date your employment ended.

If your Dependent:

- (a) becomes disabled by the 60th day after your employment ends; and
 - (b) is covered for Social Security Disability Income benefits;
- then coverage for you and any Covered Dependents may be continued for up to 29 months, from the date your employment ended.

DENTAL COVERAGE CONTINUATION
(Continued)

You must send the Company a copy of the Social Security Administration's notice of disability status:

- (a) within 60 days after they find that you are disabled, and before the 18-month continuation period expires; and again
- (b) within 30 days after they find that you are no longer disabled.

(3) **Subsequent Qualifying Event.** If your Dependent:

- (a) is a Qualified Beneficiary; and
- (b) has a subsequent Qualifying Event during the 18- or 29-month continuation period;

then coverage for that Covered Dependent may be continued for up to 36 months, from the date your employment ended.

Loss of Dependent Eligibility. If your Covered Dependent's eligibility ends, due to a Qualifying Event **other than** your termination of employment; then that Dependent's coverage may be continued for up to 36 months, from the date of the event. Such events may include:

- (1) your death, divorce, legal separation, or Medicare entitlement; and
- (2) your child's reaching the age limit, getting married or ceasing to be a full-time student.

One or more subsequent Qualifying Events may occur during your Covered Dependent's 36-month period of continued coverage; but coverage may not be continued beyond 36 months, from the date of the first Qualifying Event.

Medicare Entitlement. If your eligibility under the Policy ends due to a Qualifying Event and you become entitled to Medicare after electing COBRA continuation coverage, then your coverage may not be continued. Coverage may be continued for your Covered Dependents for up to 36 months from date of the first Qualifying Event.

If your eligibility under the Policy continues beyond Medicare entitlement, but later ends due to a Qualifying Event; then your Covered Dependents may continue coverage for up to:

- (1) 36 months from your Medicare entitlement date; or
- (2) 18 months from the date of the first Qualifying Event (whichever is later).

Coverage may not be continued beyond 36 months, from the date of the first Qualifying Event.

NOTICE REQUIREMENTS. The Group Policyholder is required by law to notify the Company within 30 days after the following Qualifying Events:

- (1) your termination of employment, hours reduction or retirement; and
- (2) your death or becoming entitled to Medicare benefits.

You (or other Qualified Beneficiary):

- (1) must notify the Group Policyholder within 60 days after the later of:
 - (a) the date of a divorce; a legal separation; or a child's ceasing to be an eligible Dependent, as defined by the Policy; or
 - (b) the date the coverage would end as a result of one of these events; and
- (2) must notify the Company within 60 days of the Social Security Administration's finding that you or your Dependent became disabled within 60 days after your termination of employment.

DENTAL COVERAGE CONTINUATION

ELECTION. To continue Dental Insurance, you must notify the Group Policyholder of such election within 60 days from the latest of:

- (1) the date of the Qualifying Event;
- (2) the date coverage would otherwise end due to the Qualifying Event; or
- (3) the date the Group Policyholder sends notice of the right to continue.

Payment for the cost of the insurance for the period prior to the election must be made to the Group Policyholder, within 45 days after the date of such election. Subsequent payments are to be made to the Group Policyholder, in the manner described by the Group Policyholder. The Group Policyholder will remit all payments to the Company.

TERMINATION. Continued coverage will end at the earliest of the following dates:

- (1) the end of the maximum period of continued coverage shown above;
- (2) the date the Policy or the Employer's participation under the Policy terminates;
- (3) the last day of the period of coverage for which premium has been paid, if any premium is not paid when due;
- (4) the date on which:
 - (a) you again become covered under the Policy;
 - (b) you become entitled (covered) for benefits under Medicare; or
 - (c) you become covered under any other group dental plan, as an employee or otherwise.

OTHER CONTINUATION PROVISIONS. If any other continuation privilege is available to you under the Policy, it will apply as follows.

- (1) **FMLA.** If you continue coverage during leave subject to the Family and Medical Leave Act (FMLA); then COBRA continuation may be elected from the day after the FMLA continuation period ends.
- (2) **Other.** If you continue coverage under any other continuation privilege under the Policy; then that continuation period will run concurrently with any COBRA continuation period provided above.

Another continuation privilege may provide a shorter continuation period, for which the Employer pays all or part of the premium. In that event, your share of the premium may increase for the rest of the COBRA continuation period provided above.

ROLLOVER OF CALENDAR YEAR MAXIMUM

ELIGIBILITY. A Covered Person meets this provision's eligibility conditions if he or she was covered prior to the last three months of a calendar year (prior to October, November, or December) and remains covered on the following January 1st. If the Covered Person becomes covered in October, November or December, the Covered Person will meet this provision's eligibility conditions if he or she remains covered on the January 1st that next follows the calendar year during which he or she was covered within the first nine months of such calendar year. For example, the Covered Person is covered under this Policy beginning on February 1, 2018; he or she meets this provision's eligibility requirements on January 1, 2019. The Covered Person becomes covered under this Policy beginning on October 1, 2018; he or she meets this provision's eligibility requirements on January 1, 2020.

BENEFIT. A Covered Person may be eligible for a rollover of a portion of the previous calendar year's unused Calendar Year Maximum, as follows.

Rollover Amount. The "Rollover Amount" is the amount by which a Covered Person's Calendar Year Maximum may be increased each calendar year, if the Covered Person:

- (1) meets this provision's eligibility conditions; and
- (2) received dental benefits under the Policy that fall within the Eligible Range, for claims incurred in the previous calendar year.

The maximum for any service with a Lifetime Maximum, such as Orthodontic (Type 4) services, may not be increased.

Eligible Range. The "Eligible Range" describes the range of dental benefits, if any, for Type 1, 2, or 3 services that a Covered Person must receive under the Policy, for claims incurred in the previous calendar year, in order to be eligible for a Rollover Amount. If the amount of benefits received for claims incurred in the previous calendar year does not fall within the Eligible Range, no Rollover Amount is accrued for that year. An incurred claim must be paid within 60 days following the end of the calendar year in which it was incurred. Deductibles and coinsurance amounts do not apply to the Eligible Range.

Rollover Account Balance. The "Rollover Account Balance" is a Covered Person's unused cumulative Rollover Amount, subject to the Maximum Account Balance shown in the table below. When a claim is paid using the Rollover Amount, the Rollover Account Balance will be reduced by that amount.

Preferred Provider Bonus. A "Preferred Provider Bonus" will be added to the Rollover Amount for a calendar year if:

- (1) the Covered Person qualifies for a Rollover Amount, as described above; and
- (2) all of the benefits a Covered Person receives for claims incurred for Type 1, 2, or 3 services in the previous calendar year were for services provided by Participating Dentists.

Calendar Year Maximum	Eligible Range	Rollover Amount without Preferred Provider Bonus	Rollover Amount with Preferred Provider	Maximum Rollover Account Balance
\$1,500	\$1 to \$800	\$350	\$500	\$1,250

EFFECTIVE DATE OF ROLLOVER AMOUNT. Any Rollover Amount for which a Covered Person is eligible will be added to the Rollover Account Balance 65 days following the end of the calendar year during which the Rollover Amount was accrued.

USE OF ROLLOVER AMOUNTS. Rollover Amounts, if available, are used only when the Covered Person's Calendar Year Maximum is reached.

LOSS OF ROLLOVER AMOUNTS. All Rollover Amounts previously added to the Rollover Account Balance will be lost if a Covered Person has any break in coverage under the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 1 PROCEDURES – DIAGNOSTIC & PREVENTIVE SERVICES**

- **ROUTINE ORAL EXAMINATIONS**
 - * up to two per calendar year
 - * includes comprehensive evaluation, no more than one per Dentist in 3 years

- **DENTAL X-RAYS**
 - * x-rays taken for orthodontia are not covered under this provision
 - **Bitewing films**
 - * up to two sets per calendar year, including any bitewings taken as part of a full mouth series
 - * includes any vertical bitewings
 - **Panoramic x-rays; or**
 - **Full mouth x-rays, including periapical x-rays and bitewings**
 - * one complete full mouth series or panoramic film, no more than once every three years
 - **Other dental x-rays**
 - * maximum of six per calendar year

- **PROPHYLAXIS (Routine Cleanings)**
 - * up to three per calendar year
 - * includes polishing of teeth and removal of plaque, calculus and stains

- **FLUORIDE TREATMENTS**
 - * one treatment per calendar year
 - * for Dependent children through age 18
 - * includes fluoride varnish for high-risk patients
 - * does not include take-home or over-the-counter treatments

- **SPACE MAINTAINERS (Passive Appliance)**
 - * one appliance per site while covered under this provision
 - * for Dependent children through age 18
 - * for the purpose of maintaining spaces created by the premature loss of primary teeth
 - * includes all adjustments within six months after installation
 - * does not include repairs or replacement costs

- **SEALANTS**
 - * one treatment per tooth, no more than once in any 36-month period
 - * for Dependent children through age 13
 - * for the occlusal surface of unrestored and non-decayed first and second permanent molars only

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

LIST OF COVERED DENTAL PROCEDURES
TYPE 1 PROCEDURES – DIAGNOSTIC & PREVENTIVE SERVICES

- **EMERGENCY TREATMENT**
 - **Emergency palliative treatment**
 - * Palliative treatment is limited to:
 - * opening and drainage of a tooth when no endodontics is to follow
 - * opening and medicating
 - * smoothing down a chipped tooth
 - * dry socket treatment
 - * pericoronitis treatment
 - * treatment for aphthous ulcers
 - Benefits are payable only if services are rendered in order to relieve dental pain or dental injury
- **SEDATIVE FILLINGS**
 - * to relieve pain
 - * not covered if used as a base or liner under a restoration

SPECIMEN

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 2 PROCEDURES – BASIC SERVICES**

- **EXAMINATIONS**
 - **Oral examinations**, problem-focused and/or emergency exams (other than routine periodic exams)
 - * up to two per calendar year
 - * Benefits are payable for an emergency examination or for emergency palliative treatment, but not both in the same visit
- **INJECTION OF ANTIBIOTICS**
 - * by the Dentist, in the Dentist's office
- **FILLINGS**
 - **Filling**
 - * benefits for composite fillings of posterior teeth will be limited to the amount payable for an equivalent amalgam filling
 - * multiple restorations on the same tooth will be treated as one restoration with multiple surfaces; and multiple restorations on one surface or adjacent surfaces will be treated as one restoration
 - * replacement fillings for a tooth or tooth surface which was filled within the last 24 months are not covered
 - **Pin retention, in addition to restoration**
- **EXTRACTIONS AND ORAL SURGERY**
 - * includes local anesthesia and routine post operative visits
 - * extractions of asymptomatic teeth, except third molars (wisdom teeth), are not covered
 - * extractions and surgical exposure of teeth, when related to orthodontic treatment, are not covered under this provision; however, if Covered Dental Procedures include orthodontic procedures, there may be coverage under that provision
 - **Simple extraction**
- **ADMINISTRATION OF ANESTHESIA**
 - **General anesthesia or I.V. sedation**
 - * administered in the Dentist's office by the Dentist or other person licensed to administer anesthesia
 - * payable in connection with:
 - * a complex cutting procedure;
 - * a documented health history that would require the administration of anesthesia;
 - * a child through 6 years of age; or
 - * a physically or developmentally disabled Covered Person
 - * not covered when benefits for the accompanying surgical procedure are not payable
 - * not covered when administered due to patient anxiety
 - * anesthesia, when related to orthodontic treatment, is not covered under this provision; however, if Covered Dental Procedures include orthodontic procedures, there may be coverage under that provision

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 PROCEDURES – MAJOR SERVICES**

- **CONSULTATIONS**
 - * provided by a Dentist other than the Dentist providing any treatment
 - * payable if no other services are rendered

- **PREFABRICATED STAINLESS STEEL OR RESIN CROWNS**
 - * resin crowns are covered for anterior and bicuspid teeth only
 - * replacement for a crown which was placed within the last 24 months is not covered

- **EXTRACTIONS AND ORAL SURGERY**
 - * includes local anesthesia and routine post operative visits
 - * extractions of asymptomatic teeth, except third molars (wisdom teeth), are not covered
 - * extractions and surgical exposure of teeth, when related to orthodontic treatment, are not covered under this provision; however, if Covered Dental Procedures include orthodontic procedures, there may be coverage under that provision
 - **Surgical removal of erupted tooth**
 - **Removal of impacted tooth** (soft tissue, partially or completely bony)
 - **Surgical exposure of impacted or unerupted tooth**, to aid eruption
 - **Excision of hyperplastic tissue**
 - **Excision of pericoronal gingiva**
 - **Removal of exposed roots**
 - **Surgical removal of residual tooth roots**
 - **Excision of lesions, malignant or benign tumors**
 - **Radical resection of bone for tumor with bone graft**
 - **Incision and removal of foreign body from soft tissue**
 - **Removal of foreign body from bone**
 - **Maxillary sinusotomy for removal of tooth fragment or foreign body**
 - **Suture of soft tissue wound**
 - * excludes closure of surgical incisions
 - **Incision and drainage of abscess**
 - **Frenulectomy**
 - **Sialolithotomy and Sialodochoplasty**
 - **Dilation of salivary duct**
 - **Sequestrectomy for osteomyelitis or bone abscess**
 - **Closure of fistula**, salivary or oroantral
 - **Reimplantation of tooth or tooth bud due to an accident**
 - **Alveolectomy** (with or without extractions)
 - **Vestibuloplasty**
 - **Removal of exostosis of the maxilla or mandible**
 - * includes removal of tori
 - **Biopsy and examination of oral tissue**
 - * includes brush biopsy

- **REPAIR of PROSTHETICS**
 - * no benefits are payable within six months of installation
 - **Repair of dentures**
 - * repair of complete denture includes repair of broken base and replacement of missing or broken teeth
 - * repair of partial dentures includes repair of acrylic saddles on base, cast framework, repair or replacement of broken clasp, and replacement of missing or broken teeth
 - **Repair or recementation of inlays, crowns and bridges**

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 PROCEDURES – MAJOR SERVICES**

- **ENDODONTICS** (treatment of diseases of root canal, periapical tissue and pulp chamber)
 - **Pulp cap**, direct or indirect
 - * not covered if done on the same day as the permanent restoration
 - **Pulpotomy**
 - * primary teeth only
 - **Gross pulpal debridement**
 - **Root canal therapy**
 - * permanent teeth only
 - * includes necessary x-rays and cultures
 - * retreatment of previous root canal therapy covered once per tooth per lifetime
 - **Root canal obstruction: non-surgical treatment**
 - **Incomplete endodontic therapy, inoperable or fractured tooth**
 - **Internal root repair of perforation defects**
 - **Apexification**
 - **Apicoectomy**
 - **Root amputation**
 - **Hemisection**
- **PERIODONTICS** (treatment of disease of the soft tissue or bone surrounding the tooth)
- **PERIODONTAL MAINTENANCE CLEANING**
 - * up to two per calendar year
 - * following active periodontal therapy
 - * not covered if performed less than 3 months following periodontal surgery or scaling and root planing
- **NON-SURGICAL PERIODONTAL SERVICES**
 - * not covered unless x-rays and pocket depth charting for each tooth confirm that the bone and attachment loss establish the Dental Necessity for treatment
 - * benefit payment may be based on tooth, sextant or quadrant
 - **Full-Mouth Debridement**
 - * one treatment per lifetime
 - **Scaling and root planing**, for pathological alveolar bone loss
 - * one treatment in any 24-month period
 - * not covered if performed less than 3 months following periodontal surgery
 - **Localized delivery of chemotherapeutic agent by means of a controlled release vehicle**
 - * following active periodontal therapy which has failed to resolve the condition
 - * one per tooth in any 36-month period
 - * not payable within 60 days of periodontal therapy

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 PROCEDURES – MAJOR SERVICES**

• **PERIODONTAL SURGERY**

- * not covered unless x-rays and pocket depth charting for each tooth confirm that the bone and attachment loss establish the Dental Necessity for treatment
- * surgical treatment includes post operative visits
- * one operative session per quadrant in any 36-month period
- * benefits for multiple periodontal surgeries within the same quadrant on the same day will be paid based on the most comprehensive procedure provided that day

- **Gingivectomy or gingivoplasty**
- **Osseous surgery**
- **Soft tissue graft**
- **Bone replacement graft**
- **Subepithelial connective tissue graft**
- **Guided tissue regeneration**

- * not covered under this provision if performed in a site where the tooth has been extracted

- **Crown lengthening**

• **PROSTHODONTICS – Fixed or Removable**

Services to replace teeth extracted or accidentally lost

- * includes adjustments, within six months of the placement date
- * benefits are not payable for temporary or provisional services

- **Bridge abutments and pontics (fixed)**

- * replacement including a dental implant is limited to one time in any five consecutive years from the placement date of the same or any other type of prosthetic at the same site, unless replacement is required due to an accidental Injury

- **Dentures, complete (upper or lower) or partial (upper or lower) or unilateral partial (removable)**

- * fees for partial dentures include all conventional clasps, rests and teeth
- * includes addition of teeth or clasp(s) to an existing partial denture
- * replacement including a dental implant is limited to once in any five consecutive years, per denture, from the placement date of the same or any other type of prosthetic at the same site, unless replacement is required due to an accidental Injury, provided the existing denture is not serviceable

- **Adjustments to dentures**, more than six months after installation

- **Tissue conditioning**

- * one per arch per calendar year

- **Reline of complete or partial denture**

- * one per calendar year, per denture

- **Rebase of complete or partial denture**

- * once in any 5-year period, per denture

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 PROCEDURES – MAJOR SERVICES**

- **Dental implants**
 - * not covered for claimants prior to age 16
 - * implants are limited to one per tooth in any five consecutive years; or sooner, if a replacement is required because of an accidental dental injury
- **Surgical placement of implant body**
- **Implant prosthetics**
 - * implant-supported crown
 - * abutment-supported crown
 - * implant abutment (includes placement)
 - * implant-supported retainer
 - * abutment-supported retainer
- **Other implant procedures**
 - * implant maintenance procedures
 - * repair implant abutment
 - * repair implant-supported prosthesis
 - * removal of implant body
- **Bone replacement graft**, at the site of an extracted tooth
 - * one per site while covered under the Policy
- **Guided tissue regeneration**, at the site of an extracted tooth
 - * one per site while covered under the Policy
- **MAJOR RESTORATIONS**
 - * inlays, onlays, veneers, and crowns are covered only when needed due to substantial loss of tooth structure caused by decay or accidental injury to teeth and when the tooth cannot be restored by other more conservative methods
 - * benefits are not payable for the placement of an inlay, onlay, veneer, or crown within five years since the placement date of an inlay, onlay, veneer, or crown on the same tooth, unless replacement is required due to an accidental injury
 - * benefits are not payable for temporary or provisional services
 - * temporary services in place for one year or more are considered to be permanent services and are subject to the Policy's frequency limitations
 - * not covered for claimants prior to age 16
- **Inlays**
- **Onlays**
- **Crowns and posts**
- **Crown build-up**, in conjunction with a payable crown
- **Cast post and core**, in conjunction with a payable crown
- **Cast post**, as part of a payable crown
- **Veneers**

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

**LIST OF COVERED DENTAL PROCEDURES
TYPE 4 PROCEDURES – ORTHODONTICS
(FOR DEPENDENT CHILDREN)**

- **ORTHODONTICS**

Active and passive services related to the guidance and alignment of teeth

- **Diagnostic services**
 - * **Examinations**
 - * **X-rays**
 - * **Diagnostic casts or study models**
- **Treatment plan**
- **Orthodontic extractions**
 - * includes anesthesia, if Necessary
- **Transseptal Fibrotomy**
- **Orthodontic appliances**

SPECIMEN

Note: Covered Dental Procedures are subject to the Alternative Procedures provision of the Policy.

PRIOR PLAN CREDIT

ELIGIBILITY. A Covered Person is eligible for Prior Plan Credit if:

- (1) the Schedule of Benefits shows that the Prior Plan Credit provision applies;
- (2) the Covered Person is covered under:
 - (a) your Employer's prior group dental plan; or
 - (b) the prior dental plan of an affiliate or an entity acquired by your Employer after the Policy's effective date;on the day before Dental Expense Benefits under the Policy take effect for the Employer, affiliate, or acquired company; and
- (3) the Covered Person immediately becomes covered under this dental plan on the day the Employer's, affiliate's, or acquired company's Dental Expense Benefits under the Policy take effect.

EFFECT OF PRIOR PLAN CREDIT ON BENEFITS. If this provision applies, then your or your Dependent's Dental Expense Benefits will be payable as follows.

- (1) Orthodontia Benefits paid by the prior plan will be applied toward the Lifetime Maximum for Type 4 services (Child Orthodontia) under the Policy.
- (2) That person's continuous months of coverage under the prior plan just before it terminated will count toward the Policy's Benefit Waiting Period for Type 2 services (Basic Care) or Type 3 services (Major Care), if any.
- (3) Your Dependent child's continuous months of coverage under the prior plan just before it terminated will also count toward any Benefit Waiting Period for Type 4 services (Child Orthodontia) under the Policy; but only if both the prior plan and the Policy provide orthodontia benefits.

CONTINUITY OF COVERAGE

ELIGIBILITY. You or your Dependent is eligible for credit upon transfer from another employer's group dental plan if the Schedule of Benefits shows that the Continuity of Coverage provision applies and:

- (1) you:
 - (a) are covered under a previous employer's group dental plan within 31 days before Dental Expense Benefits under the Policy take effect for you and coverage with the group dental plan terminates; and
 - (b) immediately become covered under this dental plan on the earliest day that the Dental Expense Benefits under the Policy can take effect.
- (2) your Dependent:
 - (a) is covered under an employer's group dental plan within 31 days before Dental Expense Benefits under the Policy takes effect and coverage with the group dental plan terminates;
 - (b) immediately becomes covered under this dental plan on the earliest day that the Dental Expense Benefits under the Policy can take effect; and
 - (c) you are covered for Group Dental Expense Benefits under the Policy.

EFFECT OF CONTINUITY OF COVERAGE ON BENEFITS. If this provision applies, then your or your Dependent's Dental Expense Benefits will be payable as follows.

- (1) Any amounts used to satisfy that person's Deductible under the prior plan will be credited toward the satisfaction of his or her Deductible under the Policy; provided:
 - (a) the expenses would be Covered Expenses under the Policy;
 - (b) the expenses are incurred during the same Calendar Year in which Dental Expense Benefits under the Policy take effect; and
 - (c) you send the Company a claim worksheet explaining the benefits paid by the prior plan.
- (2) Benefits paid by the prior plan in the same Calendar Year as the Policy takes effect will be applied towards the Calendar Year Maximum under the Policy.
- (3) Orthodontia Benefits paid by the prior plan will be applied toward the Lifetime Maximum for Type 4 services (Child Orthodontia) under the Policy.
- (4) That person's continuous months of coverage under the prior plan just before it terminated will count toward the Policy's Benefit Waiting Period for Type 2 Procedures (Basic Care) or Type 3 services (Major Care), if any.
- (5) That person's continuous months of coverage under the prior plan just before it terminated will also count toward any Benefit Waiting Period for Type 4 services (Child Orthodontia) under the Policy; but only if both the prior group dental plan and the Policy provide orthodontia benefits.

**IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE
TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
(For insurers declared insolvent or impaired on or after September 1, 2011)**

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association (“the Association”) administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas (**regardless of where the policyholder lived when the policy was issued**)
- Residents of other states, **ONLY** if the following conditions are met:
 - (1) The policyholder has a policy with a company domiciled in Texas;
 - (2) The policyholder’s state of residence has a similar guaranty association; and
 - (3) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder’s state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of \$500,000 for basic hospital, medical-surgical, and major medical insurance, \$300,000 for disability or long term care insurance, or \$200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of \$100,000 under one or more policies on a single life; or
- Death benefits up to a total of \$300,000 under one or more policies on a single life; or
- Total benefits up to a total of \$5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of \$250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of \$250,000 on any one life; or
- Present value of unallocated benefits up to a total of \$5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- \$300,000 on any one life with the exception of the \$500,000 health insurance limit, the \$5,000,000 multiple owner life insurance limit, and the \$5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance
Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.texas.gov