



Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

November 11, 2008

Diane Kilmer  
Manatts Inc  
1771 Old 6 Road  
Brooklyn, IA 52211

**The Lincoln National Life  
Insurance Company**  
8801 Indian Hills Drive  
Omaha, NE 68114-4066  
toll free (800) 423-2765  
[www.LFG.com](http://www.LFG.com)

Re: Policy No. 00040D010231 (Dental)  
Group I.D. MANATTS

Dear Ms. Kilmer:

Enclosed you will find Amendment No. 3 and a revised policy. As requested, we added Valley Environmental Services, LLC as a participating employer. The billing location for this group is # 763503. This amendment was effective October 1, 2008.

Revised generic certificates are located on The Lincoln National Life Insurance Company website, [www.jpfig.com](http://www.jpfig.com). A supply of printed certificates can be requested from Client Services at the telephone number below.

If you have any questions on this change, please feel free to contact your broker or your Customer Service Representative at 800-423-2765. Thank you for giving The Lincoln National Life Insurance Company an opportunity to serve you.

Sincerely,

The Lincoln National Life Insurance Company

Enclosures

cc: Ahold Fay Rosenberg Inc  
Jason Jodlowski, Kansas City Regional Group Office

AMENDMENT NO. 3

TO BE ATTACHED TO AND MADE PART OF GROUP POLICY NO.: 00040D010231

ISSUED TO: Manatts Inc

It is agreed that the above policy be replaced with the attached Policy, which is revised and dated October 1, 2008.

The effective date of this amendment is October 1, 2008; but only with respect to losses incurred on or after that date. Nothing contained in this amendment shall change any of the terms and conditions of this Policy; except as stated above.

**THE LINCOLN NATIONAL LIFE INSURANCE COMPANY**

  
\_\_\_\_\_  
Officer of the Company

# 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 (402) 361-7300

Group Policyholder

Manatts Inc

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In consideration of the Group Policyholder's application for this Policy and payment of all premiums when due, The Lincoln National Life Insurance Company agrees to make the payments provided in this Policy to the persons entitled to them.

The first premium for this Policy is due on its effective date. Subsequent premiums are due on July 1, 2007, and on the same day of each month after that. Policy anniversaries will be each January 1st; unless shown otherwise on the Premium Rate Schedule inside.

The provisions and conditions set forth on the following pages are a part of this Policy, as fully as if recited over the signatures below.

The Lincoln National Life Insurance Company has executed this Policy at its Group Insurance Service Office in Omaha, Nebraska. The issue date of this Policy is June 1, 2007.

  
SECRETARY

  
PRESIDENT

## GROUP DENTAL INSURANCE POLICY

No. 00040D010231

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## **SCHEDULE OF BENEFITS**

### **CLASSIFICATION**

Class 1      All Full-Time Employees

**ELIGIBILITY WAITING PERIOD** (For date coverage begins, refer to "Effective Date" section)

- (a) None for employees who were hired on or before the Policy issue date.
- (b) 30 days of continuous Active Work for employees who were hired after the Policy issue date.

**SCHEDULE OF BENEFITS (CONTINUED)**

**BENEFITS FOR CLASS 1**

Eligible Class: All Full-Time Employees

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

Benefit Waiting Period:

Type 2 Procedures: 3 Months  
Type 3 Procedures: 6 Months

**DENTAL BENEFITS**

**CALENDAR YEAR DEDUCTIBLE**

for Type 2 and 3 Procedures (combined)

INDIVIDUAL	\$100
FAMILY	\$300

**PERCENT PAYABLE**

Type 1 - Diagnostic & Preventive Services	100%
Type 2 - Basic Services	50%
Type 3 - Major Services	50%

**CALENDAR YEAR MAXIMUM**

for Type 1, 2 and 3 Procedures (combined) \$1,000

## 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 Group Policyholder's place of business; or
- (2) any other business location designated by the Group Policyholder.

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; or
- (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. This includes a Military Leave or an approved Family or Medical Leave that is not due to the Employee's own health condition.

**ANNUAL ENROLLMENT PERIOD** means the period in the calendar year, not to exceed 31 days, during which the Group Policyholder allows eligible Employees to purchase or make changes in their Employee or Dependent Dental Coverage. New hires only have a 120-day window to enroll. The Annual Enrollment Period dates designated by the Group Policyholder are as follows:

- (1) For Seasonal Employees rehired to Full-Time employment each year there will be an Annual Enrollment Period beginning April 1<sup>st</sup> and ending May 31<sup>st</sup> for employees to purchase Employee or Dependent Dental Coverage. Dental Coverage elected during this Annual Enrollment Period will become effective the June 1<sup>st</sup> following the Annual Enrollment Period.
- (2) For All Full-Time Employees, each year there will be an Annual Enrollment Period beginning December 1<sup>st</sup> and ending December 31<sup>st</sup> for employees to purchase or make changes in their Employee or Dependent Dental Coverage. Dental Coverage elected during this Annual Enrollment Period will become effective the January 1<sup>st</sup> following the Annual Enrollment Period.

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

**APPROPRIATE TREATMENT** (includes **APPROPRIATE**) means the range of services and supplies by which a dental condition may be treated, which falls within the accepted standards 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 this Policy before that type of service becomes eligible for coverage.

**CHANGE IN FAMILY STATUS** means a marriage, divorce, birth, death or change of employment or eligibility status or other event which qualifies under the requirements of Section 125 of the Internal Revenue Code of 1986, as amended. Change in Family Status also means the involuntary loss of comparable coverage under a spouse's employee benefit plan.

**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.

**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 this Policy is in effect.

## DEFINITIONS

(continued)

**COVERED EXPENSES** means expenses which:

- (1) are incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures; and
- (2) do not exceed this Policy's Usual and Customary allowances. A description of the method used for determining the Usual and Customary allowance is available upon request.

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 this Policy for those procedures for which a claim is being submitted. Covered Expenses are subject to the terms and limitations of this Policy.

**COVERED PERSON** means an eligible Employee or an eligible Dependent for whom the coverage provided by this 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. NOTE: Benefits shall be paid for covered dental services, regardless of the discipline of the provider of the service, as long as the services are performed by a duly licensed physician or Dentist.

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

**DEPENDENT DENTAL COVERAGE** means the coverage provided by this 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 this Policy.

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

**EMPLOYEE** means a full-time employee of the Group Policyholder:

- (1) whose employment with the Group Policyholder is the employee's principal occupation;
- (2) who is regularly scheduled to work at such occupation at least 30 hours each week;
- (3) who is a member of an employee class which is eligible for coverage under this Policy; and
- (4) who is a citizen of the United States or who legally works in the United States.

**DEFINITIONS**  
**(continued)**

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

**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.

**GROUP POLICYHOLDER** means the person, partnership, corporation or trust, as shown on the Title Page of this Policy. It can also mean the Participating Employer, if applicable.

**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 this Policy. Damage resulting from chewing or biting food or other objects is not considered to be an Injury.

**DEFINITIONS**  
**(continued)**

**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 professional standards for dental practice, consistent with current scientific evidence and clinical knowledge;
- (4) on the List of Covered Dental Procedures contained in this 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 this 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 this Policy.

**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.

**DEFINITIONS**  
**(continued)**

**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 accepted standards of dentistry.

**USUAL AND CUSTOMARY (U&C)** means the maximum expense covered by this 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 this Policy.

## GENERAL PROVISIONS

**ENTIRE CONTRACT.** The entire contract between the parties consists of:

- (1) this Policy and the Group Policyholder's application (a copy of which is included with this Policy);
- (2) the Participating Employer's Participation Agreement, if any; and
- (3) the Covered Employees' enrollment forms, if any.

All statements made by the Group Policyholder, Participating Employers, if any, and Covered Employees are representations and not warranties. No statement made by a Covered Employee will be used to contest the coverage provided by this Policy; unless:

- (1) it is contained in a written statement signed by the Covered Employee; and
- (2) a copy of the statement is furnished to the Covered Employee.

**AUTHORITY TO AMEND CONTRACT.** Only an Officer of the Company located in the Group Insurance Service Office in Atlanta, Georgia, or Omaha, Nebraska, may change this Policy or extend the time for payment of any premium. No change will be valid unless it is made in writing and signed by the Company Officer.

No person other than a Company Officer, or a Group Insurance Service Office employee designated by the Officer, has the authority, expressed or implied, to:

- (1) determine the insurability of a group or any individual within the group;
- (2) make a contract in the name of the Company; or
- (3) amend or waive any provision of this Policy.

**INCONTESTABILITY.** Except for the non-payment of premiums, the Company may not contest the validity of this Policy as to any Covered Person after his or her coverage has been in force for two years during his or her lifetime.

**NONPARTICIPATION.** This Policy will not be entitled to share in the surplus earnings of the Company.

**INFORMATION TO BE FURNISHED.** The Group Policyholder or Participating Employer may be required to furnish any information needed to administer this Policy. Clerical error by the Group Policyholder or Participating Employer will not:

- (1) affect the amount of coverage which would otherwise be in effect; or
- (2) continue coverage which otherwise would be terminated.

Once an error is discovered, an equitable adjustment in premium will be made. If a premium adjustment involves the return of unearned premium, the amount of the return will be limited to the three month period which precedes the date the Company receives proof such an adjustment should be made.

The Company may inspect any of the Group Policyholder's or Participating Employer's records which relate to this Policy.

**MISSTATEMENT OF AGE.** If a Covered Person's age has been misstated, premiums will be subject to an equitable adjustment. If the amount of benefit depends upon age; then the benefit will be that which would have been payable, based upon the person's correct age.

**CERTIFICATES.** The Group Policyholder or Participating Employer will be furnished with individual certificates of coverage for delivery to each Covered Employee. These certificates summarize the benefits provided by this Policy. If there is a conflict between this Policy and the certificate, this Policy will control.

**CONFORMITY WITH STATE STATUTES.** If any provision of this Policy conflicts with any applicable state law, the provision will be deemed to conform to the minimum requirements of the law.

**WORKERS' COMPENSATION.** This Policy is not to be construed to provide benefits required by Workers' Compensation laws.

**COMPANY'S DISCRETIONARY AUTHORITY.** By purchasing this Policy, the Group Policyholder or Participating Employer grants the Company the discretion and final authority to resolve all questions arising from the administration, interpretation and application of this Policy. This authority includes the right to determine:

- (1) eligibility for coverage;
- (2) entitlement to benefits;
- (3) the amount of benefits payable; and
- (4) the amount and sufficiency of information reasonably required to make such decisions.

In making any decision, the Company may rely on the accuracy and completeness of any information furnished by the Group Policyholder or Participating Employer or any Covered Person. Decisions made by the Company in the exercise of its discretionary authority shall be conclusive and binding. Failure by the Company to enforce any provision of this Policy does not render that provision unenforceable.

The Group Policyholder or Participating Employer, as plan sponsor, agrees that the Group Policyholder or Participating Employer retains full responsibility for the legal and tax status of its benefits program; and releases the Company from all responsibility for the reporting and the design of the program; and from all other responsibilities not accepted in writing by a designated Officer in the Company's Group Insurance Service Office.

**CURRENCY.** All premiums and all claims will be payable in United States dollars.

## PROVISIONS APPLICABLE TO PARTICIPATING EMPLOYERS

A Participating Employer has no rights under this Policy except as provided in this Section. The Participating Employer will be responsible for all premiums payable with respect to any of its employees who are Covered Persons under this Policy.

**PARTICIPATING EMPLOYER** means an employer who has been approved by the Company for participation in the coverage provided by this Policy. The following are Participating Employers:

United Concrete, Inc.

Valley Environmental Services, LLC

**EFFECTIVE DATE.** As it applies to any Participating Employer, the Effective Date of this Policy will be the later of:

- (1) the date this Policy is issued;
- (2) the first day of the Coverage Month following the Company's approval of the employer's Participation Agreement; or
- (3) a date agreed upon by the Company, the Participating Employer, and the Group Policyholder.

**TERMINATION.** A Participating Employer's participation under this Policy ends on the earliest of the following dates:

- (1) the date the employer no longer meets the definition of a Participating Employer;
- (2) the date the Participating Employer suspends active business operations, is placed in bankruptcy or receivership, dissolves, merges or relocates;
- (3) the date the Participating Employer without good cause, fails to:
  - (a) promptly furnish the Company any information it may reasonably require; or
  - (b) perform its duties pertaining to this Policy in good faith;
- (4) the last day of the Coverage Month for which premium is paid;
- (5) the last day of the Coverage Month in which the Company receives the Participating Employer's written request to cease participation; or
- (6) the date the Company terminates the coverage under this Policy for all Participating Employers in this state.

On the day participation ends, Policy coverage will terminate for all the Participating Employer's employees and their Dependents. If an employer ceases to be a Participating Employer, it may not be one again until it is reapproved by the Company.

An Employer will also cease to be a Participating Employer on the date that participation in Employee Dental Coverage is lower than the greater of:

- (1) 25% of eligible employees; or
- (2) 10 enrolled employees.

In determining the above participation rates, "eligible employees" will not include any employee who does not enroll, because it would result in duplicate coverage under this Policy as an Employee and a Dependent at the same time.

## **ELIGIBILITY AND EFFECTIVE DATES FOR EMPLOYEE DENTAL COVERAGE**

**ELIGIBILITY.** An Employee becomes eligible for the coverage provided by this Policy on the latest of:

- (1) the Policy's date of issue;
- (2) the date coverage for a Participating Employer becomes effective, if employed by that Participating Employer; or
- (3) the date the Eligibility Waiting Period is completed.

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

**ENROLLMENT.** An Employee may enroll for Employee Dental Coverage only:

- (1) when first eligible;
- (2) during any Annual Enrollment Period; or
- (3) within 31 days following a qualifying Change In Family Status, provided the change in coverage is consistent with the new family status.

**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 the Employee becomes eligible for the coverage;
- (2) the date the Employee resumes Active Work, if not Actively at Work on the day he or she becomes eligible. The Employee will be deemed Actively at Work on any regular non-working day, if he or she:
  - (a) is not totally disabled or hospital confined on that day; and
  - (b) was Actively at Work on the regular working day before that day;
- (3) the first day of the Coverage Month coinciding with or next following the date the Employee makes written application for coverage; and signs:
  - (a) a payroll deduction order; or
  - (b) an order to pay premiums from the Employee's Section 125 Plan account, if any contributions are paid through a Section 125 Plan;and pays the first month's premium to the Company.

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 the Covered Employee becomes eligible for the increase, if Actively at Work on that day; or
- (2) the day the Covered Employee resumes 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 the Covered Employee is Actively at Work.

**ANNUAL ENROLLMENT PERIOD.** An Employee again becomes eligible to enroll, re-enroll, or change benefit options for Employee Dental Coverage under this Policy during the Group Policyholder's Annual Enrollment Period. An Employee who terminates coverage under this Policy and subsequently re-enrolls during an Annual Enrollment Period will again be subject to the Policy's Benefit Waiting Period(s).

## **TERMINATION OF EMPLOYEE DENTAL COVERAGE**

**TERMINATION.** An Employee's coverage will terminate on the earliest of:

- (1) the date this Policy is terminated (see the Policy Termination section);
- (2) the last day of the Coverage Month in which the Covered Employee requests termination of coverage;
- (3) the date through which premium has been paid on the Covered Employee's behalf;
- (4) the end of the period for which the last required premium has been paid;
- (5) the last day of the Coverage Month in which the Covered Employee ceases to be in a class of Employees which is eligible for coverage under this Policy;
- (6) with respect to a benefit for a specific type of dental service, the date the portion of this Policy providing benefits for that type of service terminates; or
- (7) the last day of the Coverage Month in which the Covered Employee's employment with the Group Policyholder or Participating Employer terminates.

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

**DISABILITY.** If the Covered Employee is disabled due to illness or injury; then coverage may be continued until the earliest of:

- (1) the date coverage has been continued for three Coverage Months after the disability begins;
- (2) the date the Covered Employee is no longer disabled; or
- (3) the date coverage would otherwise terminate, if the Covered Employee had remained an Active Employee;

provided premium payments are made on the Covered Employee's behalf.

**LAY-OFF OR LEAVE OF ABSENCE.** If the Covered Employee ceases work due to a temporary layoff or an approved leave of absence; then coverage may be continued:

- (1) for six Coverage Months after the layoff or leave of absence begins;
- (2) provided premium payments are made on the Covered Employee's behalf.

**MILITARY LEAVE OF ABSENCE/TERMINATION OF EMPLOYMENT DUE TO MILITARY SERVICE.** If a Covered Employee goes 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.

**REINSTATEMENT OF COVERAGE.** The Company will reinstate Dental Coverage and waive any Eligibility Waiting Period or new Benefit Waiting Period if:

- (1) a Covered Employee's coverage ends due to termination of employment, reduction of hours, or layoff, and he or she returns to qualifying full-time employment within 12 months of that event;
- (2) a Covered Employee goes on an approved leave of absence, and he or she returns to qualifying full-time employment within six months of that event; or
- (3) a Covered Employee's coverage ends due to military service of more than 30 days, and he or she applies for or returns to qualifying full-time employment:
  - (a) by the 14th day after completing military service of 31 to 180 days;
  - (b) by the 90th day after completing military service of 181 days or longer; or
  - (c) within 2 years if disabled upon completing such military service.

The Employee's accumulated leave for military service may not exceed 5 years; except as provided by federal law.

To reinstate coverage, the Employee must enroll within 31 days after resuming Active Work; sign a payroll deduction order or Section 125 Plan election, if required; and pay the first month's premium to the Company. Coverage will become effective as shown in the Effective Date section of this Policy. An Employee who resumes Active Work or enrolls later will be treated as a new Employee.

## **ELIGIBILITY FOR DEPENDENT DENTAL COVERAGE**

**DEPENDENT** means a person who is a Covered Employee's:

- (1) legal spouse, who is not legally separated from the Covered Employee;
- (2) unmarried child less than 25 years of age;
- (3) unmarried child, who is at least 25 years of age but less than 30 years of age, if attending an accredited educational institution for the minimum number of hours required to maintain full-time student status there; or
- (4) unmarried child age 25 years or older, who is:
  - (a) continuously unable to earn a living because of a physical or mental disability; and
  - (b) chiefly dependent upon the Covered Employee 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) a Covered Employee's natural child or legally adopted child;
- (2) a child placed with the Covered Employee for the purpose of adoption, from the date of placement;
- (3) a child for whom the Covered Employee is required by court order to provide dental coverage;
- (4) a stepchild who resides in the Covered Employee's household; and who is chiefly dependent on the Covered Employee for support; and
- (5) a foster child:
  - (a) who resides in the Covered Employee's household;
  - (b) who is chiefly dependent on the Covered Employee for support; and
  - (c) for whom the Covered Employee has assumed full parental responsibility and control.

**ELIGIBILITY.** A Covered Employee becomes eligible to enroll for Dependent Dental Coverage on the latest of:

- (1) the date the Covered Employee becomes eligible for Employee Dental Coverage;
- (2) the issue date of this Policy; or
- (3) the date the Covered Employee first acquires a Dependent.

A Covered Employee again becomes eligible to enroll for Dependent Dental Coverage under this Policy:

- (1) within 31 days following a qualifying Change in Family Status; or
- (2) during any Annual Enrollment Period.

Any Benefit Waiting Period(s) will apply.

An Employee must be covered for Employee Dental Coverage to cover his or her Dependents.

**ANNUAL ENROLLMENT PERIOD.** An Employee again becomes eligible to enroll, re-enroll, or change benefit options for Dependent Dental Coverage under this Policy during the Group Policyholder's Annual Enrollment Period. If an Employee terminates Dependent Dental Coverage under this Policy and subsequently re-enrolls during an Annual Enrollment Period, the 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 the Covered Employee becomes eligible for Dependent Dental Coverage;
- (2) the first day of the Coverage Month coinciding with or next following the date the Covered Employee makes written application for Dependent Dental Coverage; and, if additional premium is required, the Employee signs:
  - (a) a payroll deduction order; 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 pays the first month's Dependent premium to the Company.

**COURT ORDERED COVERAGE.** If coverage is provided to a child based on a court order which requires the Covered Employee 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 a Covered Employee acquires a new Dependent, coverage for the new Dependent will become effective on the date the Dependent is acquired; provided:

- (1) the Employee completes 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 a Covered Employee acquires a newborn Dependent child, the child will be automatically covered for the first 31 days following birth. If the Covered Employee elects not to enroll the newborn child and pay any additional premium within 31 days following birth, the newborn child's coverage will terminate.

## **TERMINATION OF DEPENDENT DENTAL COVERAGE**

**TERMINATION.** Dental Coverage on a Dependent will cease on the date he or she ceases to be an eligible Dependent, as defined in this Policy.

Dependent Dental Coverage will cease for all of the Covered Employee's Dependents on the earliest of:

- (1) the date the Covered Employee's Dental Coverage terminates;
- (2) the date Dependent Dental Coverage is discontinued under this Policy;
- (3) the last day of the Coverage Month in which the Covered Employee ceases to be in a class of employees eligible for Dependent Dental Coverage;
- (4) the last day of the Coverage Month in which the Covered Employee requests that the Dependent Dental Coverage be terminated;
- (5) with respect to a benefit for a specific type of dental service, the date the portion of this Policy providing benefits for that type of service terminates; or
- (6) the date through which premium has been paid on behalf of the covered Dependents.

**SURVIVING DEPENDENTS.** If Employee Dental Coverage terminates due to the Covered Employee's death, Dependent Dental Coverage may be continued:

- (1) for three Coverage Months; or any longer period, if required by state or federal law;
- (2) provided the Group Policyholder submits the premium on behalf of the surviving Dependents; and this Policy remains in force.

**REINSTATEMENT OF DEPENDENT COVERAGE.** The Company will reinstate a Dependent's Dental Coverage and waive any Eligibility Waiting Period, or new Benefit Waiting Period if a Dependent's coverage ends due to the Covered Employee's:

- (1) termination of employment, reduction of hours, or layoff, and the Covered Employee returns to qualifying full-time employment within 12 months of that event;
- (2) approved leave of absence, and the Covered Employee returns to qualifying full-time employment within six months of that event; or
- (3) military service of more than 30 days, and the Covered Employee applies for or returns to qualifying full-time employment:
  - (a) by the 14th day after completing military service of 31 to 180 days;
  - (b) by the 90th day after completing military service of 181 days or longer; or
  - (c) within 2 years if disabled upon completing such military service.

The Employee's accumulated leave for military service may not exceed 5 years; except as provided by federal law.

To reinstate coverage, the Covered Employee must enroll eligible Dependents within 31 days after resuming Active Work; sign a payroll deduction order or Section 125 Plan election, if required, and pay the first month's Dependent premium to the Company.

## **PREMIUMS AND PREMIUM RATES**

**PAYMENT OF PREMIUMS.** No coverage provided by this Policy will be in effect until the first premium for such coverage is paid. For coverage to remain in effect, each subsequent premium must be paid on or before its due date. The Group Policyholder is responsible for paying all premiums as they become due. Premiums are payable on or before their due dates at the Company's Group Insurance Service Office.

**GRACE PERIOD.** A grace period of 31 days from the due date will be allowed for the payment of each premium after the first. During the grace period, this Policy will remain in effect. However, the Group Policyholder will remain liable for payment of a pro rata premium for the time this Policy remained in force during the grace period.

**PREMIUM RATE CHANGE.** The Company may change any premium rate:

- (1) the date this Policy's terms are changed; or
- (2) the date the Company's liability is changed due to a change in federal, state or local law;
- (3) the date the Company's liability is changed because the Group Policyholder (or any covered division, subsidiary or affiliated company) relocates, dissolves or merges, or is added to or removed from this Policy;
- (4) the date any coverage for one or more classes ceases to be provided under this Policy;
- (5) when the number of Employees covered by this Policy changes by 15% or more from the number covered on this Policy's effective date or the most recent anniversary; or
- (6) on any premium due date after this Policy's first anniversary, or any later rate guarantee date agreed upon by the Company.

Unless the Company and the Group Policyholder agree otherwise, the Company will give at least 31 days' advance written notice of any increase in premium rates.

**PREMIUM AMOUNT.** The amount of premium due on each due date will be the total of the premium amounts obtained by multiplying:

- (1) each rate shown in the Premium Rate Schedule; by
  - (2) the number of employee and family units covered;
- and then adding the monthly billing fee, if any.

For premium purposes, the effective date of any change in coverage is the first day of the Coverage Month which coincides with or follows the change. Changes will not be pro-rated daily.

### **PREMIUM RATE SCHEDULE**

#### Monthly Dental Rates

Employee Only Coverage	\$14.85 per employee
Employee and Spouse Coverage	\$29.81 per family unit
Employee and Children Coverage	\$31.49 per family unit
Employee, Spouse & Children Coverage	\$50.61 per family unit

The above rates are guaranteed until January 1, 2009, unless any of the Policy's terms or the Company's liability are changed, as described in parts 1 through 6 of the PREMIUM RATE CHANGE section, above.

After that, any increase in premium will be as shown in the renewal letter.

## POLICY TERMINATION

**TERMINATION BY THE COMPANY.** To terminate this Policy, the Company must give the Group Policyholder at least 31 days' advance written notice of its intent to do so. The Company may terminate coverage if:

- (1) the number of Covered Employees is less than ten;
- (2) part of the premium is paid by Covered Employees or through a Section 125 plan; and for Employee Dental Coverage, less than 25% of the eligible Employees are covered (or less than 60% of eligible employees with dependents are insured for any dependent dental coverage);
- (3) all of the premium is paid from the Group Policyholder's general funds:
  - (a) for Employee coverage; and less than 100% of eligible Employees are covered by the Policy; or
  - (b) for Employee and Dependent Coverage; and less than 100% of eligible Employees and Dependents are covered by this Policy;
- (4) the Group Policyholder, without good cause, fails to:
  - (a) promptly furnish any information which the Company may reasonably require;
  - (b) perform its duties pertaining to this Policy in good faith;
- (5) the Company terminates all other policies where permitted by their terms which provide dental benefits in the same state in which this Policy was issued; or
- (6) state law otherwise requires this Policy to be terminated.

In determining the above participation rates, "eligible employees" will not include any employee who declines to enroll, because it would result in duplicate coverage:

- (1) under this Policy as an employee and a dependent at the same time; or
- (2) under this Policy and another group dental plan with his or her spouse's employer.

**TERMINATION BY GROUP POLICYHOLDER.** The Group Policyholder may terminate this Policy at any time by giving the Company advance written notice. Coverage will then terminate:

- (1) on the date the Company receives the notice; or
- (2) any later date the Group Policyholder and the Company have agreed upon.

The Group Policyholder remains responsible for the payment of premiums to the date of termination.

**AUTOMATIC TERMINATION.** This Policy will terminate without any action on the part of the Company on the day before the due date of any premium which remains unpaid at the end of the grace period. The Group Policyholder remains responsible for the payment of premiums to the date of termination.

## **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 Policy.

## **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 accepted standards of dental practice; 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, a Covered Person may use the Dental Claim Procedure for Predetermination of Benefits, described in this Policy.

## LIMITATIONS AND EXCLUSIONS

Covered Expenses will not include, and Dental Expense Benefits will not be payable, for:

- (1) any procedure begun:
  - (a) before the Covered Person was covered under this Policy, subject to the Prior Carrier Credit Provision, if included in this Policy; or
  - (b) after termination of the Covered Person's coverage under this 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 this Policy;
  - (d) does not meet accepted standards of dental practice; or
  - (e) is provided by a physician or other health care provider and is beyond the scope of such physician's or other health care provider's license.
- (3) charges which exceed Covered Expenses, as defined in this Policy. Benefits will not be payable when:
  - (a) total benefit payments would exceed the annual maximum benefits payable under this Policy; or
  - (b) services exceed the frequency limitations contained in this Policy.
- (4) procedures which are subject to a Benefit Waiting Period, until that Benefit Waiting Period has been satisfied.
- (5) Orthodontic Procedures.
- (6) any treatment or services which:
  - (a) are for mainly cosmetic purposes (facings or veneers on crowns or pontics distal to the second bicuspid will be considered cosmetic); or
  - (b) are related to the repair or replacement of any prior cosmetic procedure.
- (7) services related to:
  - (a) congenital or developmental malformations, including congenitally missing teeth, unless required by state law; or
  - (b) the repair or replacement of third molars (wisdom teeth) with prostheses.
- (8) bone grafts or any regenerative procedure in an extraction site.
- (9) orthognathic recording, orthognathic surgery, osteoplasty, osteotomy, LeFort procedure, stomatoplasty or magnetic resonance imaging (MRIs).
- (10) initial placement of any prosthetic appliance or fixed bridge; unless such placement is needed to replace one or more functioning natural teeth extracted while the Covered Person is covered under this Policy, subject to the Prior Carrier Credit Provision, if included in this Policy. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth.

- (11) the retreatment or adjustment, recementation, reline, rebase, replacement or repair of cast restorations, crowns and prostheses, when made by the same Dentist or dental office which provided the initial service, within 6 months of the completion of the service.
- (12) the replacement of:
  - (a) any full or partial denture, within five years; or
  - (b) fixed prosthetic (crown, inlay or onlay restoration, or fixed bridge) within eight years;of the date of the last placement of these items. If a replacement is required because of an accidental dental injury sustained while the Covered Person is covered under this Policy, it will be a Covered Expense. (Damage resulting from biting food or other objects is not considered to be an accidental injury.)
- (13) the insertion, maintenance or removal of implants, and any related expenses.
- (14) specialized procedures, including:
  - (a) precision or semi-precision attachments;
  - (b) precious metals for removable appliances;
  - (c) overlays and overdentures; or
  - (d) personalization or characterization.
- (15) duplicate prosthetics, or for initial placement or replacement of athletic mouth guards, bruxism appliances or any appliance to correct harmful habits; and for replacement of:
  - (a) space maintainers; or
  - (b) misplaced, lost or stolen dental appliances.
- (16) appliances, restorations or procedures, or their modifications, that:
  - (a) alter vertical dimension;
  - (b) restore or maintain occlusion or for occlusal adjustment or equilibration;
  - (c) splint teeth or replace tooth structure lost as a result of erosion, abfraction, abrasion or attrition; or
  - (d) surgically or non-surgically treat disturbances of the temporomandibular joint (TMJ), or other craniomandibular or temporomandibular disorders, except as required by law.
- (17) charges for services provided by:
  - (a) an ambulatory surgical facility;
  - (b) a hospital;
  - (c) any other facility; or
  - (d) an anesthesiologist.
- (18) analgesia, sedation, hypnosis or acupuncture, for anxiety or apprehension.
- (19) any medications administered outside the dentist's office or for prescription drugs.
- (20) charges which do not directly provide treatment for a dental injury or condition, such as:
  - (a) the completion of claim forms;
  - (b) broken appointments;
  - (c) interest or collection charges;
  - (d) sales 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, histopathologic exams or pulp vitality testing; or
  - (g) duplication of x-rays or other dental records.

- (21) 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 this 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;
  - (c) charges for pre- and post-operative care;
  - (d) temporary dental services (for example, a temporary crown), which are considered to be part of the permanent service. If the temporary service is billed separately, benefits for the temporary service will be deducted from the amount payable for the permanent service.
- (22) duplication of services.
- (23) charges for which the Covered Person is not liable, or which would not have been made had no coverage been in force.
- (24) a Covered Person's dental injury or condition:
  - (a) for which he or she is eligible for benefits under Workers' Compensation or any similar law (except when an employer disputes the Workers' Compensation claim);
  - (b) arising out of, or in the course of, work for wage or profit; or
  - (c) sustained while performing military service.
- (25) 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) a Covered Person's active participation in a riot.
- (26) treatment rendered by a Dentist or dental hygienist:
  - (a) who ordinarily resides in the Covered Person's household; or
  - (b) who is related to the Covered Employee or Dependent by blood, marriage or legal adoption. "Related" persons include the Employee's or Dependent's spouse, siblings, parents, children and grandparents.
- (27) root planing; unless the presence of periodontal disease (bone and attachment loss of 4mm or more) is confirmed by x-rays and pocket depth charting of each tooth involved.

## COORDINATION OF DENTAL EXPENSE BENEFITS

**EFFECT ON BENEFITS.** If a Covered Person is covered by another Plan, the Dental Expense Benefits under this 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 Policy 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 Policy:
  - (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.

**BENEFIT SAVINGS.** The amount by which this Plan's benefits have been reduced due to such coordination will accrue during the Claim Period. This amount will be used to pay any Allowable Expenses which:

- (1) are incurred by that Claimant during the same Claim Period; and
- (2) are not otherwise paid by any 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 the Covered Person 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 this 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) the Covered Person. A Covered Person who claims benefits under this Policy 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.

## 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) the Covered Employee's name, address and certificate number, if available; and
- (3) the patient's name and relationship to the Covered Employee.

**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 the Covered Employee 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 the Covered Employee's 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 the claimant 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 this Policy will be paid immediately after the Company receives complete proof of claim and confirms liability.

**TO WHOM PAYABLE.** Dental Expense Benefits will be paid to the Covered Employee; 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) a covered Dependent child's custodial parent or custodian; or
  - (b) the provider, due to that parent's or custodian's assignment.

## **CLAIM PROCEDURES** **(Continued)**

**NOTICE OF CLAIM DECISION.** The Company will send the Covered Employee 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 the claimant 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 the claimant 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 the claimant a written delay notice:

- (1) by the 15<sup>th</sup> 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 the Covered Employee does 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 the claimant 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, the Covered Employee 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.

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

The Company will review the claim and send the Covered Employee 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 this Policy; and
- (4) describe the claimant's right to access relevant claim information and to bring legal action.

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

**Exception:** If the Company needs more information from the claimant 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.

## **CLAIM PROCEDURES (Continued)**

**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 this Policy, the claimant must first seek two internal reviews of the adverse claim decision, in accord with the above provision. If an ERISA claimant brings legal action under Section 502(a) of ERISA after the required review; then the Company will waive any right to assert that he or she 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.

**COMPANY'S DISCRETIONARY AUTHORITY.** Except for the functions that this Policy clearly reserves to the Group Policyholder or Employer, the Company has the authority to:

- (1) manage this Policy and administer claims under it; and
- (2) interpret the provisions and to resolve questions arising under this Policy.

The Company's authority includes (but is not limited to) the right to:

- (1) establish and enforce procedures for administering this Policy and claims under it;
- (2) determine Employees' eligibility for insurance and entitlement to benefits;
- (3) determine what information the Company reasonably requires to make such decisions; and
- (4) resolve all matters when a claim review is requested.

Any decision the Company makes, in the exercise of its authority, shall be conclusive and binding; **subject to** the Covered Employee's rights to:

- (1) request a state insurance department review; or
- (2) bring legal action.

**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 this Policy.

To use this procedure:

- (1) the Covered Employee 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; and
- (3) the Company will verify current eligibility and determine what benefits would be payable for the procedures listed.

## 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) this Policy remains in force.

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

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

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

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

But it does **not** include the Covered Employee's 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 the Covered Employee's termination of employment; then coverage for the Covered Employee and any 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 the Covered Employee's termination of employment is for gross misconduct, coverage may **not** be continued for the Covered Employee or any 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 the Covered Employee:

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

If the Covered Employee's Dependent:

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

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

- (a) within 60 days after they find that the Covered Person is disabled, and before the 18-month continuation period expires; and again
- (b) within 30 days after they find that he or she is no longer disabled.

(3) **Subsequent Qualifying Event**. If the Covered Employee's 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 the Covered Employee's employment ended.

**Loss of Dependent Eligibility**. If a Covered Dependent's eligibility ends, due to a Qualifying Event **other than** the Covered Employee's 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) the Covered Employee's death, divorce, legal separation, or Medicare entitlement; and
- (2) a 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 the 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 the Covered Employee's eligibility under this Policy ends due to a Qualifying Event and he or she becomes entitled to Medicare after electing COBRA continuation coverage, then coverage may not be continued for the Covered Employee. Coverage may be continued for any Covered Dependents for up to 36 months from the date of the first Qualifying Event.

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

- (1) 36 months from the Covered Employee's 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) the Covered Employee's termination of employment, hours reduction or retirement; and
- (2) the Covered Employee's death or becoming entitled to Medicare benefits.

The Covered Employee 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 this 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 a Covered Person was disabled within 60 days after the Covered Employee's termination of employment.

**ELECTION**. To continue Dental Insurance, the Covered Person 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 this Policy or the Employer's participation under this 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) the Covered Person again becomes covered under this Policy;
  - (b) the Covered Employee becomes entitled (covered) for benefits under Medicare; or
  - (c) the Covered Person becomes covered under any other group dental plan, as an employee or otherwise.

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

- (1) **FMLA.** If a Covered Employee continues 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 a Covered Person continues coverage under any other continuation privilege under this 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, the Covered Person's share of the premium may increase for the rest of the COBRA continuation period provided above.

## **LIST OF DENTAL PROCEDURES**

### **TYPE I PROCEDURES**

#### **DIAGNOSTIC & PREVENTIVE SERVICES**

##### **DIAGNOSTIC SERVICES**

###### **ROUTINE ORAL EXAMINATIONS**

- up to two per calendar year

###### **DENTAL X-RAYS**

- x-rays taken for orthodontia are not covered under this provision of this Policy

###### **Bitewing films**

- up to four per calendar year, including any bitewings taken as part of a full mouth series
- includes any vertical bitewings

###### **Panoramic x-rays, including bitewings; or**

###### **Full mouth x-rays, with periapical x-rays and bitewings**

- one complete full mouth series or panoramic film in any five consecutive years

###### **Other dental x-rays, needed to diagnose a specific dental condition**

- maximum of 6 per calendar year

##### **PREVENTIVE CARE**

###### **PROPHYLAXIS (Routine Cleanings)**

- up to two 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 15

###### **SPACE MAINTAINERS (Passive Appliance)**

- for Dependent children through age 15
- 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 and replacement costs

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

## **TYPE II PROCEDURES**

### **BASIC SERVICES**

#### **SEALANTS:**

- for Dependent children through age 15
- for the occlusal surface of unrestored and non-decayed first and second permanent molars only
- one treatment per tooth in any 36 consecutive months

#### **BASIC RESTORATIONS**

##### **Fillings:**

- 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 12 months are not covered
- includes pin retention, in addition to restoration

##### **Prefabricated stainless steel or resin crowns**

- for covered Dependent children through age 15
- one per tooth, in any 5 consecutive years

#### **ORAL SURGERY**

- oral surgery includes local anesthesia and routine post operative visits

##### **Simple extraction**

##### **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

- extractions of asymptomatic teeth, except third molars (wisdom teeth), are not covered
- where related to orthodontic treatment, extractions and surgical exposure of teeth are not covered under this provision

##### **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**

## **TYPE II PROCEDURES (continued)**

### **PATHOLOGY**

#### **Biopsy and examination of oral tissue**

### **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 Necessary complex oral surgery procedure
- payable when underlying medical condition, age or health factors render anesthesia medically necessary
- not covered when benefits for the accompanying surgical procedure are not payable
- not covered when administered due to patient anxiety
- anesthesia for orthodontic procedures is not covered under this provision of this Policy

### **REPAIR OF PROSTHETICS**

- no benefits are payable within six months of installation if the repair is provided by the same Dentist who installed the prosthetic

#### **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**

### **OTHER BASIC SERVICES**

#### **Oral examinations, problem focused**

#### **Emergency examinations**

- 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

### **EMERGENCY TREATMENT**

#### **Emergency palliative treatment**

Palliative treatment is limited to:

- opening and drainage of a tooth when no endodontics is to follow
- smoothing down a chipped tooth
- dry socket treatment
- pericoronitis treatment
- treatment for apthous ulcers

Benefits are payable only if services are rendered in order to relieve dental pain or dental injury

### **CONSULTATIONS**

#### **Diagnostic services**

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

#### **Sedative fillings**

- to relieve pain
- not covered if used as a base or liner under a restoration

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

## **TYPE III PROCEDURES**

### **MAJOR SERVICES**

**ENDODONTICS** (treatment of diseases of root canal, periapical tissue and pulp chamber)

**Pulpotomy** - primary teeth only

**Gross pulpal debridement**

**Root canal therapy**

- permanent teeth only
- includes necessary x-rays and cultures
- retreatment not covered for 12 months

**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 therapy is not covered unless bone and attachment loss is 4 mm or greater, and confirmed by x-rays and pocket depth charting for each tooth
- surgical treatment includes post operative visits
- 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
- benefit payments may be based on tooth, sextant or quadrant

**Gingivectomy or gingivoplasty**

- one per site in each 36 consecutive months

**Osseous surgery**

- one per site in each 36 consecutive months

**Soft tissue graft**

- one per site in each 36 consecutive months

**Bone replacement graft**

- one per site in each 36 consecutive months

**Subepithial connective tissue graft**

- one per site in each 36 consecutive months

**Guided tissue regeneration**

**Crown lengthening**

**Debridement**

- one treatment in each 24 consecutive months

**Scaling and root planing**, for pathological alveolar bone loss

- one treatment in each 24 consecutive months
- not covered if performed less than three months following periodontal surgery

**Periodontal maintenance cleanings**

- following active periodontal therapy
- four per calendar year; but no more than two in any calendar year if benefits are paid for two routine cleanings in that same calendar year
- not covered if performed less than three months following periodontal surgery

**Chemotherapeutics**, for areas of refractory disease

**localized delivery of chemotherapeutic agent by means of a controlled release vehicle**

- following active periodontal therapy which has failed to resolve the condition

## TYPE III PROCEDURES (continued)

### MAJOR RESTORATIONS

#### Inlays and onlays

#### Crowns and posts

- not covered for claimants prior to age 16
- benefits paid for a temporary crown or a provisional crown will be deducted from the allowance for a permanent crown installed on the same tooth

#### 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

- Inlays, onlays and crowns are covered only when needed due to substantial loss of tooth structure caused by decay or accidental injury to teeth, which cannot be repaired by fillings
- replacement of inlays, onlays and crowns is limited to one time in any eight years
- temporary services in place for one year or more are considered to be permanent services and are subject to this Policy's frequency limitations

### ORAL SURGERY - ALVEOLAR OR GINGIVAL RECONSTRUCTION

#### Alveolectomy (with or without extractions)

#### Vestibuloplasty

#### Removal of exostosis of the maxilla or mandible

- includes removal of tori

#### Excision of hyperplastic tissue

### PROSTHODONTICS - Fixed or Removable

Services to replace teeth extracted or accidentally lost while covered under this Policy

- precision attachments, overdentures, specialized techniques and characterizations are not covered
- temporary services in place for one year or more are considered to be permanent services and are subject to this Policy's frequency limitations

#### Bridge abutments and pontics

- replacement is limited to one time in any eight consecutive years

#### Dentures

- includes adjustments, within six months of placement
- replacement is limited to once in any five consecutive years, per denture, if the existing denture cannot be made serviceable
- fees for partial dentures include all conventional clasps, rests and teeth

#### Complete denture - upper or lower

#### Partial denture - upper or lower

- acrylic base or predominantly base cast with acrylic saddles

#### Removable unilateral partial denture

- one piece, predominantly base casting, clasp attachments (including pontics)

#### Adjustments to dentures, more than six months after installation

#### Special 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 five consecutive years, per denture

Addition of teeth or clasp(s) to existing partial denture to replace natural teeth extracted or accidentally lost while covered under this Policy

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

ISSUED TO: Manatts Inc

**FOR NEW MEXICO RESIDENTS ONLY**

**On the ELIGIBILITY FOR DEPENDENT DENTAL COVERAGE page, the definition of Dependent is amended to read as follows:**

**DEPENDENT** means a person who is a Covered Employee's:

- (1) legal spouse, who is not legally separated from the Covered Employee;
- (2) unmarried child less than 25 years of age; or
- (3) unmarried child age 25 years or older, who is unable to earn a living because of a physical or mental handicap. 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) a Covered Employee's natural child or legally adopted child, whether the Covered Employee is a custodial or non-custodial parent;
- (2) a child placed with the Covered Employee for the purpose of adoption, from the date of placement;
- (3) child for a whom the Covered Employee is required by court order to provide dental coverage;
- (4) a stepchild who resides in the Covered Employee's household; and who is chiefly dependent on the Covered Employee for support; and
- (5) a foster child:
  - (a) who resides in the Covered Employee's household;
  - (b) who is chiefly dependent on the Covered Employee for support; and
  - (c) for whom the Covered Employee has assumed full parental responsibility and control.

**This amendment applies only to Certificates delivered in the state of New Mexico. This amendment takes effect on the day the Group Policyholder's or Participating Employer's Dental Expense Benefits under this Policy take effect or each Covered Employee's effective date of coverage under the Policy; whichever is later. In all other respects, this Policy remains the same.**

**THE LINCOLN NATIONAL LIFE INSURANCE COMPANY**

  
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Officer of the Company