



The Lincoln National Life Insurance Company
A Stock Company
Home Office Location: 1300 S Clinton St, Fort Wayne, Indiana 46802
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066
(800) 423-2765 Online: www.LincolnFinancial.com

CERTIFIES THAT Group Policy No. 00001D043263 has been issued to

Native American Electric
(The Group Policyholder)

The issue date of the Policy is January 1, 2024.

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.

IMPORTANT INFORMATION REGARDING YOUR INSURANCE. If you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in its sale, or if you have additional questions; then you may contact the insurance company at the above address or phone them at (800) 423-2765. If unable to obtain satisfaction from the company or agent, you may contact the state regulatory agency at California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, Los Angeles CA 90013, <https://www.insurance.ca.gov/01-consumers/> or phone them at 1-800-927-4357 or 1-800-482-4TDD. Please have your policy number available.

NOTICE: THIS POLICY USES A PREFERRED PROVIDER ARRANGEMENT. DEDUCTIBLES, COINSURANCE AMOUNTS, AND ANNUAL MAXIMUMS FOR SERVICES PERFORMED BY IN-NETWORK AND OUT-OF-NETWORK PROVIDERS MAY DIFFER. AN INSURED PERSON'S OUT-OF-POCKET EXPENSES MAY BE HIGHER FOR SERVICES PERFORMED BY OUT-OF-NETWORK PROVIDERS. PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR MORE INFORMATION.

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.

A handwritten signature in cursive script that reads "Ellen Cooper".

PRESIDENT

**CERTIFICATE OF GROUP
DENTAL INSURANCE**

Native American Electric
00001D043263
SCHEDULE OF BENEFITS

ELIGIBLE CLASS

Class 1 All Full-Time Employees

DENTAL PREFERRED PROVIDER ORGANIZATION (PPO).

This 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 network being offered by the Policy. These Dentists are called Participating Dentists.

Use of a Participating 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 Participating Dentist.

A Directory of Participating Dentists is available from your Employer. Information about Participating Dentists is included on your ID card and may also be obtained by:

- (1) accessing the Company's web site at www.LFG.com; or
- (2) calling the Company's Client Services Department (800) 423-2765.

Most Participating Dentists prepare the necessary claim forms, and submit them to the Company for you. Benefits are based on the terms of the Policy.

IMPORTANT: If you opt to receive dental services that are not covered services under the policy, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at (800) 423-2765 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

TIMELY ACCESS TO CARE.

A Covered Person will have access to dental services provided by a Participating Dentist in a timely manner appropriate for the nature of the Covered Person's condition that is consistent with good professional practice. The Dentist's office shall schedule urgent appointments within 72 hours of the time of the request for appointment, non-urgent appointments within 36 business days of the request for appointment and preventive appointments within 40 business days of the request for appointment. The applicable wait time for any particular appointment may be extended if it has been determined and noted that a longer wait time will not have an impact on the health of the Covered Person.

If a Covered Person cannot locate a Participating Dentist for a Necessary Dental Procedure, then a Covered Person may contact the Company at (800) 423-2765. The Company will arrange for the required care with available and accessible Dentists. If a Participating Dentist is not available, the Company shall cover the Necessary Dental Procedure obtained Out-of-Network at no greater cost sharing to the Covered Person than if the Necessary Dental Procedure were obtained by an In-Network Dentist. The In-Network cost sharing includes coinsurance, Deductible and accrual of cost sharing to the In-Network Maximum.

If a Covered Person reads or speaks a language other than English, the Company will provide the Covered Person with oral translation services at no charge. A Covered Person may call member services at (800) 423-2765.

Native American Electric
00001D043263
SCHEDULE OF BENEFITS
(Continued)

OPEN ENROLLMENT PERIOD: There will be an Open Enrollment Period for one month each year beginning December 1st and ending December 31st, 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 January 1st following the Open Enrollment period.

Native American Electric
00001D043263
SCHEDULE OF BENEFITS
For
Class 1 - All Full-Time Employees

MINIMUM HOURS: 30 hours per week

ELIGIBILITY WAITING PERIOD: (For date insurance begins, refer to "Effective Date" section)
Two months of continuous Active Work

Contributions: You are not required to contribute to the cost for Employee Dental Coverage. You are required to contribute to the cost for Dependent Dental Coverage.

Benefit Waiting Period:

Type 2 Procedures:	None
Type 3 Procedures:	None

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

**Native American Electric
00001D043263
SCHEDULE OF BENEFITS
(Continued)
For
Class 1**

DENTAL BENEFITS

	PPO PLAN In-Network Services	PPO PLAN Out-of-Network Services
Calendar Year Deductible for these Procedure Types (combined)	Types 2 & 3	Types 2 & 3
INDIVIDUAL	\$50	\$50
FAMILY	\$150	\$150
Percent Payable by Insurer		
Type 1 - Diagnostic & Preventive Services	100%	100%
Type 2 - Basic Services	80%	80%
Type 3 - Major Services	50%	50%
Type 1, 2 and 3 Benefits Based On	Negotiated Fees	90 th Percentile of Usual & Customary Allowance
Calendar Year Maximum Benefit for Procedures (combined)	\$1,500 Types 1, 2 & 3	\$1,500 Types 1, 2 & 3

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 Participating Dentist, benefits are automatically assigned to that Dentist, unless the bill has been paid.

EMERGENCY DENTAL SERVICES EXCEPTION: Covered Expenses incurred as a result of an Emergency will be provided as Covered Expenses by a Participating Dentist, regardless of whether the service is provided by a Participating Dentist or a Non-Participating Dentist.

Please contact the Company in the event a Non-Participating Dentist provides for Covered Expenses as a result of an Emergency so that any claim may be paid appropriately.

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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.

ADEQUATE—See Professionally Adequate definition.

APPROPRIATE TREATMENT (includes **APPROPRIATE**) means the range of services and supplies by which a dental condition may be treated and is based on current scientific evidence and clinical knowledge. 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.

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.

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 Participating 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 network;whichever is less; or
- (2) for a Non-Participating Dentist's charges, do not exceed, the Policy's Usual and Customary allowances, for Type 1, 2 or 3 procedures.

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.

DEFINITIONS (Continued)

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.

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.

DEFINITIONS (Continued)

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.

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.

DEFINITIONS (Continued)

NECESSARY DENTAL PROCEDURE (includes **NECESSARY** and **DENTAL NECESSITY**) means a procedure, service or supply which is:

- (1) Appropriate and:
 - (a) Adequate and required for the diagnosis or treatment of a dental disease, condition or injury; and
 - (b) consistent with the Covered Person's symptoms, and with the diagnosis and treatment of the Covered Person's dental disease, condition or injury;
- (2) consistent with current scientific evidence and clinical knowledge;
- (3) on the List of Covered Dental Procedures contained in the Policy; and
- (4) 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-PARTICIPATING DENTIST means a Dentist who is not participating in the dental network being made available through the Policy.

OPEN 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.

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

PARTICIPATING DENTIST means a Dentist who:

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

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

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 a treatment that is Appropriate for a given dental condition and conforms to current scientific evidence and clinical knowledge.

DEFINITIONS
(Continued)

USUAL AND CUSTOMARY (U&C) means the maximum expense covered by the Policy. U&C allowances are determined by the zip code where the service is provided. 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.

The Group Policyholder elects the percentage level of the U&C allowance to be used as the basis for the maximum U&C allowance under 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 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 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.

DISABILITY. If you are 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 you are no longer disabled; or
 - (3) the date coverage would otherwise terminate, if you had remained an Active Employee;
- provided premium payments are made on your behalf.

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.

LAY-OFF OR LEAVE OF ABSENCE. If you cease work due to a temporary layoff or an approved leave of absence (other than an approved Family or Medical Leave or Military Leave); then coverage may be continued:

- (1) for three Coverage Months after the layoff or leave of absence begins;
- (2) provided premium payments are made on your behalf.

If your coverage is continued as provided above, but Dependent Dental Coverage is terminated; then any Dependents who are re-enrolled at a later date will be treated as Late Entrants.

LABOR DISPUTE. If you cease Active Work due to a labor dispute, and your Employer's premium contributions are required by a collective bargaining agreement; then arrangements may be made with the Employer to continue coverage for up to six months, subject to:

- (1) the conditions shown in the Policy; and
- (2) payment of the required premium by at least 75% of the Covered Employees eligible to continue. (See your Employer for further information.)

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.

**TERMINATION OF
EMPLOYEE DENTAL COVERAGE
(Continued)**

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

- (1) your coverage ends due to termination of employment, reduction of hours, or layoff, and you return to qualifying full-time employment within 12 months of that event; or
- (2) you go on an approved leave of absence, (other than for an approved Family or Medical Leave or for a Military Leave), and you return to qualifying full-time employment within six months of that event; or
- (3) you return from an approved Family or Medical Leave within:
 - (a) the period required by federal law; or
 - (b) any longer period required by a similar state law; or
- (4) your coverage ends due to military service of more than 30 days; and you apply for or return 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.

Your accumulated leave for military service may not exceed 5 years; except as provided by federal law.

To reinstate coverage, you 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 the Policy. If you resume Active Work or enroll later, you will be treated as a new Employee.

NOTICE REQUIREMENTS. If the Policy provides coverage to Participating Employers, and there are changes to the Participating Employer's coverage under the Policy which do not affect all employees of the Participating Employer, the Company will mail a notice of the change to your last known address at least 30 days prior to the effective date of the change. The changes which will require the notice be sent to you include:

- (1) an increase in premium;
- (2) a reduction or elimination of benefits; or
- (3) restricted eligibility for coverage.

ELIGIBILITY FOR DEPENDENT DENTAL COVERAGE

DEPENDENT means a person who is your:

- (1) legal spouse, who is not legally separated from you;
- (2) domestic partner who meets the criteria specified by California Family Code Section 297;
- (3) Domestic Partner, as defined below, where the domestic partnership has not been registered in the state of California;
- (4) child less than 26 years of age; or
- (5) 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).

The Company will send notice to you 90 days prior the date the Dependent reaches the limiting age shown in (4) above. The notice will notify you that the Dependent's coverage will terminate upon attainment of the limiting age, unless you submit proof of the child's total disability as described above. Upon receipt of the proof, the Company will determine if the Dependent child remains eligible. If the Company fails to make the determination by the limiting age, the Dependent child will remain covered until the determination is made.

The Policy may be replaced immediately by another group dental plan. If so, the Dependent child's coverage can be continued under the Employer's replacement plan; although fresh proof of disability may be requested by the replacement group dental plan.

"Child" includes:

- (1) your natural child, legally adopted child, or stepchild;
- (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; and
- (4) 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.

The Definition of "Domestic Partner", as used when the domestic partnership has not been registered in the state of California, means your partner, of the same or the opposite sex, when all of the following conditions are met.

You and your partner:

- (1) are age 18 or older; mentally competent; not legally married to someone else; not related to the other by blood, to a degree that would bar legal marriage; and not a party to or registered as a partner of another domestic partnership;
- (2) are in a committed, exclusive relationship with each other;
- (3) are jointly responsible for each other's welfare and financial obligations; and
- (4) have not been in another domestic partnership relationship within the prior 12 months.

Satisfactory proof that such domestic partnership exists shall be provided to the Company, upon request.

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.

**ELIGIBILITY FOR
DEPENDENT DENTAL COVERAGE
(Continued)**

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 following the date you become eligible for Dependent Dental Coverage;
- (2) the first day of the Coverage Month 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 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.

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 the Policy.

Dependent Dental Coverage will cease for all of your Dependents on the earliest of:

- (1) the date your Dental Coverage terminates;
- (2) the date Dependent Dental Coverage is discontinued under the Policy;
- (3) the last day of the Coverage Month in which you cease to be in a class of employees eligible for Dependent Dental Coverage;
- (4) the last day of the Coverage Month in which you request 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 the Policy providing benefits for that type of service terminates; or
- (6) the date through which premium has been paid on behalf of your covered Dependents.

SURVIVING DEPENDENTS. If Employee Dental Coverage terminates due to your 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 the Policy remains in force.

REINSTATEMENT OF DEPENDENT COVERAGE. The Company will reinstate your Dependent's Dental Coverage and waive any Eligibility Waiting Period, new Late Entrant Limitation Period, or new Benefit Waiting Period if a Dependent's coverage ends due to your:

- (1) termination of employment, reduction of hours, or layoff, and you return to qualifying full-time employment within 12 months of that event;
- (2) approved leave of absence, (other than for an approved Family or Medical Leave or for a Military Leave), and you return to qualifying full-time employment within six months of that event;
- (3) return from an approved Family or Medical Leave within:
 - (a) the period required by federal law; or
 - (b) any longer period required by a similar state law; or
- (4) military service of more than 30 days, and you apply for or return 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.

Your accumulated leave for military service may not exceed 5 years; except as provided by federal law.

To reinstate coverage, you 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.

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 treatment which:

- (1) the dental profession recognizes to be Professionally Adequate, in accord with generally accepted practices of dentistry; and
- (2) is both Adequate and Appropriate for the Covered Person.

The amount of the Covered Expense will be based on the treatment which is the least expensive procedure.

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.

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 provided by or under the direct supervision of a Dentist;
 - (b) is not a Necessary Dental Procedure;
 - (c) is not specifically listed as covered by the Policy; or
 - (d) 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.
- (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:
 - (a) congenital or developmental malformations, including congenitally missing teeth, unless required by state law; or
 - (b) the replacement of third molars (wisdom teeth).
- (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.

LIMITATIONS AND EXCLUSIONS
(Continued)

- (10) orthognathic recording, orthognathic surgery, osteoplasty, osteotomy, LeFort procedures, stomatoplasty, computed tomography imaging (CT scans), cone beam, or magnetic resonance imaging (MRIs).
- (11) initial placement of any prosthetic appliance; unless such placement is needed to replace one or more natural teeth extracted while you or your Dependent is covered under the Policy, subject to the Prior Plan Credit provision and the Continuity of Coverage Provision, if included in the Policy. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth.
- (12) the adjustment, recementation, reline, rebase, replacement or repair of cast restorations, crowns and prostheses, within 6 months of the completion of the service.
- (13) 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.
- (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 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.
- (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) 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.
- (17) charges for services provided by:
 - (a) an ambulatory surgical facility;
 - (b) a hospital; or
 - (c) an anesthesiologist.
- (18) except as specifically shown in the List of Covered Dental Procedures included in the Policy, analgesia, sedation, hypnosis or acupuncture, for anxiety or apprehension.

LIMITATIONS AND EXCLUSIONS
(Continued)

- (19) any medications administered outside the Dentist's office or for prescription drugs.
- (20) 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.
- (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 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.
- (22) charges for which you are not liable, or which would not have been made had no coverage been in force.
- (23) 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.
- (24) 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.

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.

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 immediately after the Company receives complete proof of claim and confirms liability.

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)

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) whether any more information is needed to support the claim; and
- (4) how you may request a review of the decision by the Company, or by the state Department of Insurance. It will include the address and phone number of their consumer complaint unit.

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.

INTERNAL 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.

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.

CLAIM PROCEDURES (Continued)

INDEPENDENT MEDICAL REVIEW. If you are a California Covered Employee, you may be eligible for an Independent Medical Review through the California Department of Insurance (the Department), when you believe that:

- (1) the Company has improperly denied or reduced benefits for an otherwise Covered Expense which involves the practice of medicine; or a Participating Dentist in its PPO network has denied, modified or delayed services otherwise covered under the Policy; and
- (2) the decision was based, in whole or in part, upon lack of Medical Necessity.

"California Covered Employee" means your Certificate was issued, amended, renewed or delivered in California; regardless of whether you work or reside in that state.

"Independent Medical Review" means a review of the Medical Necessity of the disputed procedure. It does not consider coverage or contract interpretation questions, such as:

- (1) whether you or your Dependent is eligible, is enrolled for coverage or has met any Benefit Waiting Period which applies to the disputed procedure; or
- (2) whether the disputed procedure is covered or excluded under the Policy.

Such coverage questions may be submitted to the Department for review, without an Independent Medical Review, however.

Eligibility. You may apply for an Independent Medical Review of a disputed decision, or a provider may do so on a patient's behalf; when:

- (1) you or your Dependent has received urgent dental care or emergency services, or a provider's recommendation that a proposed procedure is Medically Necessary;
- (2) the Policy's benefits have been denied or reduced, based upon lack of Medical Necessity;
- (3) an appeal has been filed in accord with the Company's Appeal Procedure; and
- (4) the disputed decision has been upheld or has not been resolved within 30 days (three days, if the proposed dental procedure is urgent).

"Urgent" means a proposed procedure is needed to prevent:

- (1) severe pain, death, loss of a major bodily function; or
- (2) other serious harm to the patient's health.

Application. You or your provider may apply to the Department for an Independent Medical Review, on a form supplied by the Company, within six months after:

- (1) the disputed decision is upheld; or
- (2) the applicable 30-day or three-day appeal period expires.

The Department will determine whether:

- (1) the disputed decision involves a question of Medical Necessity; and
- (2) there is a right to an Independent Medical Review.

The Department will then promptly notify the parties.

Documentation. Upon receipt of the Department's notice that an Independent Medical Review will be done, the Company or Participating Provider will promptly forward to the review organization:

- (1) copies of any relevant medical or dental records in its possession; and
- (2) any correspondence with the parties, concerning the disputed decision and its appeal.

At the same time, the Company will furnish copies of this information to you or your provider; except for any parts which are protected by law or legally privileged. The review organization may request further documentation from the parties.

CLAIM PROCEDURES (Continued)

Decision. Upon receipt and review of this information, the review organization's professional medical reviewer(s) will determine the Medical Necessity of the disputed procedure. Their decision will be based upon the specific patient's medical or dental condition and any of the following:

- (1) peer-reviewed scientific evidence of the procedure's effectiveness;
- (2) nationally recognized, generally accepted professional standards of medical or dental practice;
- (3) expert opinion; and
- (4) the availability of other effective treatments for the patient's condition.

Within 30 days of receipt of the application for review and supporting documents, the review organization will send the parties a written notice explaining their decision.

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 may wish to determine 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.

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
(Continued)

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.

**CERTIFICATE AMENDMENT
CAL-COBRA DENTAL COVERAGE CONTINUATION**

The following provisions comply with Cal-COBRA (the California Continuation Benefits Replacement Act). They apply when Dental Coverage is provided by an Employer with 2 to 19 eligible employees (as defined under Cal-COBRA). Any further changes made to Cal-COBRA will automatically apply.

RIGHT TO CONTINUE. So long as the Policy remains in force, coverage may be continued in accord with the following provisions, when you or your Covered Dependent:

- (1) becomes ineligible for Policy coverage due to a Qualifying Event shown below;
- (2) is not entitled to continue Policy coverage under federal COBRA law (the Consolidated Omnibus Budget Reconciliation Act of 1985).;
- (3) is not eligible for Medicare;
- (4) is not covered under another group dental plan (or, if covered, has not satisfied a pre-existing conditions limitation that applies under that plan); and
- (5) provides the Employer notice of the Qualifying Event, written election to continue, and the first premium payment. This must be done within the required time periods.

DEFINITIONS. As used in this provision, certain key terms shall be defined as follows.

"Qualifying Event" means one of the following events, if it would otherwise result in a Qualified Beneficiary's loss of Policy coverage:

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

"Qualified Beneficiary" means you or your Covered Dependent who is entitled to continue Policy coverage under Cal-COBRA, from the date of your first Qualifying Event. It also includes your natural child, legally adopted child, or child placed for adoption:

- (1) who is acquired during your 36-month continuation period; and
- (2) who is enrolled for insurance in accord with the terms of the Policy.

It does **not** include your new spouse, stepchild or foster child acquired during that continuation period.

CONTINUATION PERIODS. The maximum period of continued coverage for each Qualifying Event shall be 36 months. The following rules apply.

Termination of Employment. When eligibility ends due to your termination of employment, coverage for you and your Covered Dependents may be continued for up to 36 months from the date employment ended. Termination of employment includes a reduction in hours or retirement. Exception: If your termination of employment is for gross misconduct, coverage may **not** be continued for you or your Dependents.

Loss of Dependent Eligibility. If your Covered Dependent's eligibility ends due to a Qualifying Event **other than** your termination of employment, 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 event.

CAL-COBRA DENTAL COVERAGE CONTINUATION
(Continued)

Medicare Entitlement. If your eligibility under the Policy ends upon becoming entitled to Medicare benefits, Policy coverage:

- (1) may **not** be continued for you; but
- (2) may be continued for your Covered Dependents for up to 36 months from your Medicare entitlement date.

Your eligibility under the Policy may continue beyond Medicare entitlement, and then end upon your termination of employment or retirement. In that event, your Covered Dependents may continue coverage for up to 36 months from your date of Medicare entitlement, termination of employment or retirement (whichever is later).

NOTICE REQUIREMENTS. The Employer shall provide notice of Cal-COBRA rights, an election form, and the premium rate to a Qualified Beneficiary. This must be done within 14 days after:

- (1) your termination of employment, hours reduction or retirement; or
- (2) receiving notice of any other Qualifying Event listed below.

The notice shall be sent to the Qualified Beneficiary's last known address.

To remain a Qualified Beneficiary, you or your Covered Dependent must notify the Group Policyholder, within 60 days of:

- (1) your death, becoming entitled to Medicare, divorce or legal separation; or
- (2) your Covered Dependent's ceasing to be an eligible Dependent, as defined by the Policy.

Failure to give notice by the 60th day will disqualify a Qualified Beneficiary from Cal-COBRA continuation.

ELECTION AND PREMIUM PAYMENT. To continue Dental Coverage, you or your Covered Dependent must provide the Employer written notice 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 Employer sends notice of the right to continue.

The premium payment for the period prior to the election must be made to the Employer, within 45 days after the date of such election. The election notice and first premium payment:

- (1) may be sent by certified mail, express mail, first class mail, or private courier company; or
- (2) may be delivered personally or by other reliable means.

Failure to send the election notice and correct premium payment within the required period will disqualify a Qualified Beneficiary from Cal-COBRA continuation.

Premium for this Cal-COBRA continuation coverage will equal the rate charged to the Employer for actively employed Covered Employees and their Covered Dependents. Premium will be at the rate charged for a Covered Employee's continuation, when:

- (1) your spouse, divorced spouse, or surviving spouse continues without you; or
- (2) your child continues without either parent under that Certificate.

Subsequent payments are to be made to the Employer, who will remit them to the Company.

CAL-COBRA DENTAL COVERAGE CONTINUATION
(Continued)

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

- (1) the end of the 36-month period of continued coverage shown above;
- (2) the last day for which premium has been paid, if any premium is not paid when due;
- (3) the date when you or your Covered Dependent:
 - (a) again becomes covered under the Policy;
 - (b) becomes eligible for benefits under Medicare;
 - (c) becomes covered under any other group dental plan (or satisfies any pre-existing conditions limitation that applies under that plan); or
 - (d) commits fraud or deception in the use of Policy benefits; or
- (4) the date the Policy or the Employer's participation under the Policy terminates.*

* The Policy may be replaced immediately by another group dental plan. In that event, you or your Covered Dependent may be entitled to continue coverage under the Employer's replacement plan, for the balance of the period allowed under the Policy.

OTHER CONTINUATION PROVISIONS. You may be entitled to continue coverage during leave subject to the Family and Medical Leave Act (FMLA). If so, Cal-COBRA continuation may be elected from the day after the FMLA continuation period ends.

If you or your Covered Dependent continues coverage in accord with any other continuation privilege under the Policy, that continuation period will run concurrently with any Cal-COBRA continuation period provided above. The other continuation privilege may provide a shorter continuation period, for which the Employer pays all or part of the premium. If so, your share of the premium may increase for the rest of the Cal-COBRA continuation period provided above.

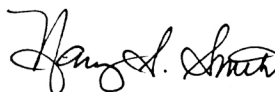
CONTINUATION UNDER REPLACEMENT PLAN. This rule applies when a Qualified Beneficiary's continuation coverage terminates under the Employer's prior group dental plan, on the day before the Policy takes effect. In that event, coverage may be continued under the Policy for the balance of the period allowed under the prior plan, so long as the Policy remains in effect. The Employer must notify Qualified Beneficiaries, within 30 days before continuation coverage will end under the prior plan. The notice:

- (1) must include the election form and premium rate required to continue under the Policy; and
- (2) must be sent to the Qualified Beneficiary's last known address.

The Qualified Beneficiary must send the Employer written election to continue and the first premium payment under the Policy, within 30 days after receiving the notice. Subsequent payments are to be made to the Employer, who will remit them to the Company.

This amendment takes effect on January 1, 2003, or on the date this Policy takes effect (whichever is later). It applies only to Covered Persons whose Cal-COBRA continuation period begins on or after January 1, 2003. In all other respects, this Policy remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

**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 one set per calendar year, including any bitewings taken as part of a full mouth series
 - * includes any vertical bitewings
- **PROPHYLAXIS (Routine Cleanings)**
 - * up to four per calendar year
 - * includes polishing of teeth and removal of plaque, calculus and stains
- **FLUORIDE TREATMENTS**
 - * two 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 14
 - * 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 60-month period
 - * for Dependent children through age 18
 - * 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 2 PROCEDURES – BASIC SERVICES**

- **DENTAL X-RAYS**
 - * x-rays taken for orthodontia are not covered under this provision
 - **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 five years
 - **Other dental x-rays**
 - * maximum of six per calendar year
- **EXAMINATIONS**
 - **Oral examinations**, problem-focused and/or emergency exams (other than routine periodic exams)
 - * up to one per calendar year
 - * Benefits are payable for an emergency examination or for emergency palliative treatment, but not both in the same visit
- **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
- **INJECTION OF ANTIBIOTICS**
 - * by the Dentist, in the Dentist's office
- **FILLINGS**
 - **Filling**, includes composite fillings
 - * 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

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

**LIST OF COVERED DENTAL PROCEDURES
TYPE 2 PROCEDURES – BASIC SERVICES
(Continued)**

- **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
- **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 2 PROCEDURES – BASIC SERVICES
(Continued)

- **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)

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

**LIST OF COVERED DENTAL PROCEDURES
TYPE 2 PROCEDURES – BASIC SERVICES
(Continued)**

- **PERIODONTAL MAINTENANCE CLEANING**
 - * up to four per calendar year, but this will be reduced by the number of routine cleanings that are paid in the same 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
 - * not covered unless x-rays and pocket depth charting for each tooth confirm that the bone and attachment loss establish Dental Necessity for treatment
 - **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
- **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**
 - **Subepithial connective tissue graft**
 - **Guided tissue regeneration**
 - * not covered under this provision if performed in a site where the tooth has been extracted
 - **Crown lengthening**

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

- **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
(Continued)**

- **PROSTHODONTICS – Fixed or Removable**

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

- * 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 eight 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 to replace natural teeth extracted or accidentally lost while covered under the Policy
- * replacement including a dental implant is limited to once in any eight 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

- **Dental implants**

- * not covered for claimants prior to age 16
- * implants are limited to one per tooth in any eight consecutive years; or sooner, if a replacement is required because of an accidental dental injury sustained while the Covered Person is covered under the Policy

- **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

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

**LIST OF COVERED DENTAL PROCEDURES
TYPE 3 PROCEDURES – MAJOR SERVICES
(Continued)**

- **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 eight 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**

- **OCCLUSAL ADJUSTMENT**

- * maximum of one adjustment per quadrant in any 36-month period

- **OCCLUSAL GUARD**

- * one in any 24-month period

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

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) 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.
- (2) Expense that person incurs for initial placement of a prosthetic appliance or fixed bridge will be covered; provided:
 - (a) the placement is needed to replace one or more natural teeth extracted while insured for Dental Expense Benefits under the Policy or under the prior group dental plan;
 - (b) the replacement would have been covered under the prior plan; and
 - (c) the extracted teeth are not third molars (wisdom teeth).

**NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

• **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent.

Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

• **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

• **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

• **Life Insurance**

80% of death benefits but not to exceed \$300,000

80% of cash surrender or withdrawal values but not to exceed \$100,000

• **Annuities and Structured Settlement Annuities**

80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed \$250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is \$300,000, regardless of the number of policies or contracts covering the individual.

• **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is \$546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

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

The Lincoln Financial Group companies* are committed to protecting your privacy. To provide the products and services you expect from a financial services leader, we must collect personal information about you. We do not sell your personal information to third parties. This Notice describes our current privacy practices. While your relationship with us continues, we will update and send our Privacy Practices Notice as required by law. Even after that relationship ends, we will continue to protect your personal information. You do not need to take any action because of this Notice, but you do have certain rights as described below.

We are committed to the responsible use of information and protecting individual privacy rights. As such, we look to leading data protection standards to guide our privacy program. These standards include collecting data through fair and lawful means, such as obtaining your consent when appropriate.

Information we may collect and use

We collect personal information about you to help us identify you as a consumer, our customer, or our former customer; to process your requests and transactions; to offer investment or insurance services to you; to pay your claim; to analyze in order to enhance our products and services; to tell you about our products or services we believe you may want and use; and as otherwise permitted by law. The type of personal information we collect depends on your relationship and on the products or services you request and may include the following:

- **Information from you:** When you submit your application or other forms, you give us information such as your name, address, Social Security number; and your financial, health, and employment history. We may also collect voice recordings or biometric data for use in accordance with applicable law.
- **Information about your transactions:** We maintain information about your transactions with us, such as the products you buy from us; the amount you paid for those products; your account balances; payment details; and your payment and claims history.
- **Information from outside our family of companies:** If you are applying for or purchasing insurance products, we may collect information from consumer reporting agencies, such as your credit history; credit scores; and driving and employment records. With your authorization, we may also collect information (such as medical information, retirement information, and information related to Social Security benefits), from other individuals or businesses.
- **Information from your employer:** If your employer applies for or purchases group products from us, we may obtain information about you from your employer or group representative in order to enroll you in the plan.

How we use your personal information

We may share your personal information within our companies and with certain service providers. They use this information to process transactions you, your employer, or your group representative have requested; to provide customer service; to analyze in order to evaluate or enhance our products and services; to gain customer insight; to provide education and training to our workforce and customers; and to inform you of products or services we offer that you may find useful. Our service providers may or may not be affiliated with us. They include financial service providers (for example, third party administrators; broker-dealers; insurance agents and brokers, registered representatives; reinsurers and other financial services companies with whom we have joint marketing agreements). Our service providers also include non-financial companies and individuals (for example, consultants; vendors; and companies that perform marketing services on our behalf). Information we obtain from a report prepared by a service provider may be kept by the service provider and shared with other persons; however, we require our service providers to protect your personal information and to use or disclose it only for the work they are performing for us, or as permitted by law. We may execute agreements with our service providers that permit the service provider to process your personal information outside of the United States, when not prohibited by our contracts and permitted by applicable law.

When you apply for one of our products, we may share information about your application with credit bureaus. We also may provide information to group policy owners or their designees (for example, to your employer for employer-sponsored plans and their authorized service providers), regulatory authorities and law enforcement officials, and to other non-affiliated or affiliated parties as permitted by law. In the event of a sale of all or part of our businesses, we may share customer information as part of the sale. **We do not sell or release your information to outside marketers who may want to offer you their own products and services; nor do we release information we receive about you from a consumer reporting agency. You do not need to take any action for this benefit.**

Security of information

We have an important responsibility to keep your information safe. We use safeguards to protect your information from unauthorized disclosure. Our employees are authorized to access your information only when they need it to perform their job responsibilities. Employees who have access to your personal information are required to keep it confidential. Employees are required to complete privacy training annually.

Your rights regarding your personal information

This Privacy Notice describes how you can exercise your rights regarding your personal information. Lincoln complies with all applicable laws and regulations regarding the provision of personal information. The rights provided to you in this Privacy Notice will be administered in accordance with your state's specific laws and regulations.

Access to personal information: You must submit a written request to receive a copy of your personal information. You may see your personal information in person, or you may ask us to send you a copy of your personal information by mail or electronically, whichever you prefer. We will need to verify your identity before we process the request. Within 30 business days of receiving your request, we will, depending on the specific request you make, (1) inform you of the nature and substance of the recorded personal information we have about you; (2) permit you to obtain a copy of your personal information; and (3) provide the identity (if recorded) of persons to whom we disclosed your personal information within two years prior to the request (if this information is not recorded, we will provide you with the names of those insurance institutions, agents, insurance support organizations or other persons to whom such information is normally disclosed). If you request a copy of your information by mail, we may charge you a fee for copying and mailing costs.

Changes to personal information: If you believe that your personal information is inaccurate or incomplete, you may ask us to correct, amend, or delete the information. Your request must be in writing and must include the reason you are requesting the change. We will respond within 30 business days from the date we receive your request.

If we make changes to your records as a result of your request, we will notify you in writing and we will send the updated information, at your request, to any person who may have received your personal information within the past two years. We will also send the updated information to any insurance support organization that gave us the information and any insurance support organization that systematically received personal information from us within the prior 7 years unless that support organization no longer maintains your personal information.

If we deny your request to correct, amend or delete your information, we will provide you with the reasons for the denial. You may write to us and concisely describe what you believe our records should say and why you disagree with our denial of your request to correct, amend, or delete that information. We will file this communication from you with the disputed information, identify the disputed information if it is disclosed, and provide notice of the disagreement to the persons and in the manner described in the paragraph above.

Basis for adverse underwriting decision: You may ask in writing for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate, or terminate your coverage.

Your state may provide for additional privacy protections under applicable laws. We will protect your information in accordance with these additional protections.

If you would like to act upon your rights regarding your personal information, please provide your full name, address and telephone number and either email your inquiry to our Data Subject Access Request Team at DSAR@lfg.com or mail to: Lincoln Financial Group, Attn: Corporate Privacy Office, 1301 South Harrison St., Fort Wayne, IN 46802. The DSAR@lfg.com email address should only be used for inquiries related to this Privacy Notice. For general account service requests or inquiries, please call 1-877-ASK-LINC.

*This information applies to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company
Lincoln Financial Distributors, Inc.
Lincoln Financial Group Trust Company
Lincoln Investment Advisors Corporation

Lincoln Life & Annuity Company of New York
Lincoln Life Assurance Company of Boston
Lincoln Retirement Services Company, LLC
Lincoln Variable Insurance Products Trust
The Lincoln National Life Insurance Company

**This Notice is effective 14 calendar days after it is made available on Lincoln's website, www.LFG.com/privacy.

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

You have received this Notice because you have applied for, or currently have, insurance coverage or an annuity ("Coverage"), that contains benefit provisions subject to the federal privacy regulations that were issued as a result of the Health Insurance Portability and Accountability Act, as amended ("HIPAA"), such as a dental plan, vision plan, or a life or annuity product with a long-term care policy (including a long-term care rider). This is Coverage that has been or will be issued by or through one of the Lincoln Financial Group insurance companies* ("Company"). Some insurance coverage and annuities (e.g., disability plans) are not subject to this Notice. If you have questions as to whether this Notice applies to you, please contact us using the contact information below. This Notice sometimes refers to the Company by using the terms "us," "we," or "our." We value our relationship with you and are committed to protecting the confidentiality and security of information we collect about you, especially health information.

We collect, use and disclose information about you to evaluate and process any requests for Coverage and claims for benefits you may make regarding your Coverage. This Notice describes how we protect the individually identifiable health information we have about you which relates to your Coverage ("Protected Health Information"), and how we may use and disclose this information. Protected Health Information includes individually identifiable information that relates to your past, present or future health, treatment or payment for health care services. This Notice also describes your rights with respect to the Protected Health Information and how you can exercise those rights.

We are required by law to maintain the privacy of your Protected Health Information; to provide you this Notice of our legal duties and privacy practices with respect to your Protected Health Information; and to follow the terms of this Notice.

The Company reserves the right to change this Notice at any time. We can make any changes effective for Protected Health Information we already have about you, as well as any Protected Health Information we receive in the future. If the revised Notice contains material changes, we will send you the revised Notice, as well as post it on the Company internet sites.

Uses and Disclosures of your Protected Health Information

The following describes when we may use and disclose your Protected Health Information with your written authorization and without your authorization:

Authorization: Except as described below, we will not use or disclose your Protected Health Information for any reason unless we have a signed authorization from you or your legal representative to use or disclose your Protected Health Information. For example, we will not share your information for marketing purposes (other than face-to-face communications or for promotional gifts of nominal value) or allow for the sale of your information without your authorization. An authorization to use or disclose any psychotherapy notes we may have will specifically state that it is an authorization for psychotherapy notes. You or your legal representative has the right to revoke an authorization in writing, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition of obtaining your Coverage.

Treatment: We may use and disclose your Protected Health Information for your treatment. For instance, a doctor or health facility involved in your care may request Protected Health Information that we hold about you in order to make decisions about your care.

Payment of Claims: We may use and disclose your Protected Health Information to obtain premiums and pay for benefits under your Coverage. For example, when you present a claim for benefits, we may obtain medical records from the doctor or health facility involved in your care to determine if you are eligible for benefits under the insurance policy and to reimburse you for services provided. Other payment-related uses and disclosures that are permitted and we may engage in include: making claim decisions, coordinating benefits with other insurers or payers, utilization review activities including precertification and preauthorization of services, billing, premium and claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing.

Health Care Operations: We may use and disclose your Protected Health Information for our insurance operations. Our insurance operations may include underwriting, enrollment, premium rating, and other activities related to the issuance, renewal or replacement of Coverage, or for reinsurance purposes. For example, when you apply for insurance, we may collect medical information from your doctor (health care provider) or a medical facility that provided you health care services to determine if you qualify for insurance. We may also use and disclose Protected Health Information to conduct or arrange for medical review, legal

services, contract for reinsurance, business planning and development, or auditing, including fraud and abuse detection and compliance programs. Protected Health Information may also be disclosed for business management and general administrative activities, including customer service, servicing our current and future customer relationships as permitted by law, resolution of internal grievances and as part of a potential sale, transfer, merger, or consolidation in order to make an informed business decision regarding any such prospective transaction. Protected Health Information may also be disclosed for the health care operations of the entity that receives the information, as long as the entity has a relationship with you and the Protected Health Information pertains to such relationship. For group plans, Protected Health Information may be collected from or disclosed to (1) your Plan Sponsor for purposes of obtaining coverage or administering your Plan or (2) any other health plan maintained by your employer to facilitate claims payments under the plan. If we use or disclose Protected Health Information for underwriting purposes, the Protected Health Information used or disclosed for that purpose will not include information that constitutes genetic information except when permitted by law.

Business Associates: We may also disclose Protected Health Information to non-affiliated business associates of ours, but only if the business associate's receipt of Protected Health Information is necessary to provide a service to us and the business associate agrees to protect the Protected Health Information in accordance with, and use it, only as allowed by, HIPAA. Examples of business associates are: billing companies, data processing companies, auditors, claims processing companies and companies that provide general administrative services.

Uses and Disclosures to Family, Friends or Others Involved in Your Care: Unless you object or direct us otherwise, we may disclose your Protected Health Information to a designated member of your family, friend, or other individual that you may identify as involved in your care or involved in the payment for your care. Should you become incapacitated, deceased, or be in an emergency medical situation and not able to provide us with your approval, we may disclose Protected Health Information about you that is directly relevant to such person's involvement in your care or payment for such care.

Whistleblowers: We strive to comply with all applicable laws and encourage our workforce to speak up if they have concerns about our business practices. If a member of our workforce believes in good faith that we have engaged in unlawful or unprofessional conduct or that our services, care, or conditions could endanger someone, we allow that person to disclose Protected Health Information to (i) a health oversight agency or public health authority authorized to investigate the conduct or (ii) an attorney retained by the employee or business associate for purposes of determining legal options with respect to the aforementioned conduct.

Workforce Member Crime Victims: We may disclose Protected Health Information to a law enforcement official when our employee is the victim of a criminal act, provided the Protected Health Information is about the suspected perpetrator and the information is limited.

Where Required by Law, for Public Health or Similar Activities: We may also disclose Protected Health Information where required or permitted by law, for public health or similar activities, the protection of you or others, legal proceedings and other reasons as provided in the HIPAA regulations. Examples of disclosures that may be required or permitted by law include releasing Protected Health Information:

- To state or local health authorities, as required by law, of particular communicable diseases, injury, birth, death, and for other required public health investigations;
- To a governmental agency or regulator with health care oversight responsibilities. These oversight activities include audits, investigations, inspections, licensure or disciplinary actions and other activities necessary for the government to monitor the health care system, government programs such as Medicare and Medicaid and compliance with civil rights laws;
- To a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death or to a funeral director;
- To public health or other appropriate authorities, as required by law, or when there is reason to suspect abuse, neglect, or domestic violence;
- To the Food and Drug Administration (FDA) for purposes related to quality, safety or effectiveness of FDA-regulated products or activities;
- If required by law to do so by a court or administrative tribunal for law enforcement purposes as permitted by law, and to comply with a subpoena or discovery request. When a subpoena or discovery request is issued by someone other than a judge, we will make reasonable efforts to notify you of such requests or to obtain an order protecting the Protected Health Information requested. We may disclose Protected Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination;
- To law enforcement to identify or locate a suspect, fugitive, material witness or missing person; if an individual is the victim or suspected victim of a crime, but only under certain conditions; if the individual dies and we suspect that death resulted from criminal conduct;

- For certain research purposes when the information has been completely deidentified or when such research is approved by an institutional review board with established rules to ensure privacy or by a privacy board with members who have appropriate professional competency with privacy rights;
- If you are a member of the military (including a foreign military) as deemed necessary by armed forces services;
- To federal officials for intelligence, counterintelligence, and other national security activities authorized by law or for the conduct of investigations or the provision of protective services to the President, foreign heads of state, or others;
- To worker's compensation agencies if necessary for your worker's compensation benefit determination;
- To avert a serious threat to someone's health or safety, including the disclosure of Protected Health Information to government or private disaster relief or assistance agencies to allow such entities to carry out their responsibilities to specific disaster situations;
- To organizations that manage organ procurement or organ, eye or tissue transplant or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplant;
- To a correctional institution or law enforcement official if necessary (1) for the provision of health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety, security, and good order of the correctional institution.

State Law Restrictions: State laws may be more stringent and may prohibit certain uses and disclosures identified in this Notice. When state law is more protective of your privacy, we will follow that state law. For example, some state laws require additional protection for records related to mental health treatment, drug and alcohol treatment, and HIV-related information. If you have a question about how we comply with your state's laws, please contact us using the information below.

Required Disclosures

The following is a description of two specific disclosures of your Protected Health Information that we are required to make.

Government Audits. We are required to disclose your Protected Health Information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with HIPAA.

Disclosures to You. When you request, we are required to disclose to you the portion of your Protected Health Information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested by you, to provide you with an accounting of most disclosures of your Protected Health Information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the Protected Health Information was not disclosed pursuant to your individual authorization. Please refer to the further description of your right to receive an accounting below. When permitted by applicable law, we may also contact you for case management or care coordination purposes to provide information about treatment alternatives or other health-related benefits or services that may be of interest to you.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights as a consumer under HIPAA concerning the Protected Health Information we have about you in our records. Any request to exercise your rights as described below should be made in writing and sent to **Lincoln Financial Group, Attn: Corporate Privacy Office - 1301 South Harrison Street, Fort Wayne IN 46802**. Also, should you wish to terminate a request for a restriction that has been accommodated, such termination request must also be in writing and sent to the same address listed above. Your request to exercise the rights described below should include the following information: your full name, address, and policy number. Generally, we will respond to these requests within 30 days of receipt.

Right to Request Restrictions: You have the right to request that we restrict or limit our use or disclosure of your Protected Health Information that would otherwise be permitted for purposes related to treatment, payment or our health care operations, including disclosure to someone who may be involved in your care or payment for your care, like a family member, or friend. While we will consider your request, we are not required to agree to your restriction. If we do agree to the restriction, we will restrict the use or disclosure of your Protected Health Information as requested, but we reserve the right to terminate the agreed to restriction if we deem appropriate. In your request to restrict use and disclosure, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on Protected Health Information uses or disclosures that are legally required or which are necessary to administer our business.

Right to Request Confidential Communications: You have the right to request that we communicate with you about Protected Health Information in a certain way or using a certain address or email address, if you make such a request in writing, send it to the address provided above, and clearly state that the disclosure of the information could endanger you. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Inspect and Copy Your Protected Health Information: In most instances, you have the right to inspect and obtain a copy of the Protected Health Information that we maintain about you. Your request must be in writing and sent to the address provided above. We will deny inspection and copying of certain Protected Health Information, for example psychotherapy notes and Protected Health Information collected by us in connection with, or in reasonable anticipation of, any legal claim or legal proceeding. We reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. In those limited circumstances that we deny your request to inspect and obtain a copy of your Protected Health Information, you may have the right to request a review of our denial. Your request to review our denial should be submitted in writing and sent to the address provided above. If the information you request is maintained electronically and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format. If the information cannot be readily produced in that form and format, we will work with you to come to an agreement on an alternative electronic form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

Right to Amend Your Protected Health Information: You have the right to request that we amend your Protected Health Information in our records if you believe it is inaccurate or incomplete. Your request must be in writing and sent to the address provided above. Your request must provide your reason(s) for seeking the amendment or correction. We will act on your request no later than 60 days after the receipt of the request, by requesting an extension, granting the amendment, in whole or in part, or denying the request, in whole or in part. We may request a single 30-day extension, to agree to accept the request, in whole or in part, or deny the request to amend PHI, in whole or in part. If an amendment or correction request is accepted, we will amend or correct all appropriate records as well as make reasonable efforts to notify others to whom we have disclosed the erroneous Protected Health Information. We may deny your request if you ask us to amend Protected Health Information that is accurate and complete; was not created by us, unless the creator of the Protected Health Information is no longer available to make the amendment; is not part of the Protected Health Information kept by or for us; or is not part of the Protected Health Information which you would be permitted to inspect and copy. If we deny your request, in whole or in part, the notice of denial will explain the basis for the denial. You have the right to file a statement of disagreement with us and any future disclosures of your Protected Health Information will include your statement.

If we are informed by another organization of an amendment to your Protected Health Information, we must amend the Protected Health Information in your record.

Right to Receive an Accounting of Disclosures of Your Protected Health Information: You have the right to request an accounting or list of disclosures we have made of your Protected Health Information in the past six (6) years. This list will not include disclosures:

- For treatment;
- For payment or health care operations;
- To law enforcement, for purposes of national security;
- To department of corrections personnel;
- Pursuant to your authorization;
- Incidental to a permitted disclosure;
- To certain persons involved in an individual's care or payment for that care;
- or directly to you.

To request this list, you must submit your request in writing to the address provided above. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years. Your request should indicate in what form you want the accounting (e.g., paper or electronic). The first list you request within a 12-month period will be free. We reserve the right to charge you for responding to any additional requests within that 12-month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to be Notified of a Breach: You have the right to be notified in the event that we (or our business associate) discover a breach of your unsecured Protected Health Information.

Right to a Paper Copy of this Notice: You have the right to obtain a paper copy of this Notice upon request, even if you agreed to receive this Notice electronically.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with us, by sending it to the address listed below. You may also file a complaint with the U.S. Department of Health and Human Services ("HHS") Office of Civil Rights. If you send your complaint to HHS by mail or fax, you should send it to the regional office of the HHS Office of Civil Rights covering the area where the potential violation occurred. You can find more information about how to file a complaint with HHS, including the addresses of the regional offices of the HHS Office of Civil Rights on the HHS website: <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html> or complaints may be sent to HHS by email to: OCRComplaint@hhs.gov. The Company supports your right to protect the privacy of your Protected Health Information. No action will be taken against you for filing a complaint.

For Further Information: For further information regarding this Notice or the Company's privacy practices, please contact **Lincoln Financial Group, Attn: Corporate Privacy Office, 1301 South Harrison Street, Fort Wayne IN 46802, or call 1-877-275-5462.**

Effective Date: This Notice is effective November 9, 2021.

*This information applies to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company

Lincoln Life & Annuity Company of New York

The Lincoln National Life Insurance Company