

SERFF Tracking Number: JEPT-126868546 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 47095
Company Tracking Number: GL11-4-DF 10
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: 2010 Dental Forms/GL11-4-DF 10 et al

Filing at a Glance

Company: The Lincoln National Life Insurance Company

Product Name: Group Dental

SERFF Tr Num: JEPT-126868546 State: Arkansas

TOI: H10G Group Health - Dental

SERFF Status: Closed-Approved-
Closed State Tr Num: 47095

Sub-TOI: H10G.000 Health - Dental

Co Tr Num: GL11-4-DF 10

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Cindi Allgire, Debbie

Disposition Date: 10/28/2010

Turek, Bonnie White, Benjamin

Davis

Date Submitted: 10/20/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 2010 Dental Forms

Project Number: GL11-4-DF 10 et al

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/28/2010

Deemer Date:

Submitted By: Benjamin Davis

Filing Description:

Re: Group Dental Forms

Forms GL11-4-DF 10 et al

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 09/28/2010

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Explanation for Other Group Market Type:

State Status Changed: 10/28/2010

Created By: Benjamin Davis

Corresponding Filing Tracking Number:

Enclosed for filing with your Department are copies of the captioned forms. These forms are new and will not replace any forms previously approved by your Department. We are requesting that these forms be approved for general use with any of our previously approved Group Policy Series GL11 and Group Certificate Series GL12 forms. They will be marketed by licensed agents and brokers.

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The insert pages allow more flexibility to our dental product and bring it more in line with what is currently offered in the market.

There is no rate impact to this filing. The enclosed Actuarial Memorandum confirms this.

We appreciate the Department's review of this filing. If you have questions, please feel free to contact me.

Benjamin Davis
Compliance Analyst
Insurance Solutions - Product Compliance
Lincoln Financial Group
8801 Indian Hills Drive
Omaha, NE 68114
Toll Free: (800) 423-265 ext. 7495
Phone: (402) 361-7495
Fax: (402) 361-2568
Email: benjamin.davis@lfg.com

Company and Contact

Filing Contact Information

Ben Davis, Compliance Specialist Benjamin.Davis@lfg.com
8807 Indian Hills Drive 402-361-7495 [Phone]
Omaha, NE 68114 402-361-2568 [FAX]

Filing Company Information

The Lincoln National Life Insurance Company CoCode: 65676 State of Domicile: Indiana
350 Church Street Group Code: 20 Company Type: Group
Hartford, CT 06103 Group Name: State ID Number:
(800) 423-2765 ext. [Phone] FEIN Number: 35-0472300

Filing Fees

Fee Required? Yes
Fee Amount: \$950.00
Retaliatory? No

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Fee Explanation: \$50.00 per form x 19 forms = \$950.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Lincoln National Life Insurance Company	\$950.00	10/20/2010	40956300

SERFF Tracking Number: JEPT-126868546 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/28/2010	10/28/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Actuarial Memorandum	Benjamin Davis	10/20/2010	10/20/2010

SERFF Tracking Number: *JEPT-126868546* *State:* *Arkansas*
Filing Company: *The Lincoln National Life Insurance Company* *State Tracking Number:* *47095*
Company Tracking Number: *GL11-4-DF 10*
TOI: *H10G Group Health - Dental* *Sub-TOI:* *H10G.000 Health - Dental*
Product Name: *Group Dental*
Project Name/Number: *2010 Dental Forms/GL11-4-DF 10 et al*

Disposition

Disposition Date: 10/28/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: JEPT-126868546 State: Arkansas
 Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 47095
 Company Tracking Number: GL11-4-DF 10
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Dental
 Project Name/Number: 2010 Dental Forms/GL11-4-DF 10 et al

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Appendix of Variability	Approved-Closed	Yes
Supporting Document	Actuarial Memorandum	Approved-Closed	No
Form	Definitions	Approved-Closed	Yes
Form	Eligibility for Dependent Dental Coverage	Approved-Closed	Yes
Form	Alternative Procedures	Approved-Closed	Yes
Form	Dental Expense Benefits -- Orthodontics for Children/Family Orthodontics	Approved-Closed	Yes
Form	Limitations and Exclusions	Approved-Closed	Yes
Form	Coordination of Benefits	Approved-Closed	Yes
Form	Dental Claims Procedures for Predetermination of Benefits	Approved-Closed	Yes
Form	Continuity of Coverage	Approved-Closed	Yes
Form	Prior Plan Credit	Approved-Closed	Yes
Form	Definitions	Approved-Closed	Yes
Form	Eligibility for Dependent Dental Coverage	Approved-Closed	Yes
Form	Alternative Procedures	Approved-Closed	Yes
Form	Dental Expense Benefits -- Orthodontics for Children/Family Orthodontics	Approved-Closed	Yes
Form	Limitations and Exclusions	Approved-Closed	Yes
Form	Coordination of Benefits	Approved-Closed	Yes
Form	Dental Claims Procedures for Predetermination of Benefits	Approved-Closed	Yes
Form	Continuity of Coverage	Approved-Closed	Yes
Form	Prior Plan Credit	Approved-Closed	Yes
Form	Coordination of Benefits Explanatory Booklet	Approved-Closed	Yes

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Amendment Letter

Submitted Date: 10/20/2010

Comments:

Attached an Actuarial Memorandum, as noted in the General Information tab.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Actuarial Memorandum

Comment:

Actuarial Memorandum for 2010 Dental forms filing.pdf

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Form Schedule

Lead Form Number: GL11-4-DF 10

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/28/2010	GL11-4-DF 10	Policy/Cont ract/Fratern al	Definitions	Initial		58.000	4DF10.pdf
		Certificate: Amendmen t, Insert Page, Endorseme nt or Rider					
Approved-Closed 10/28/2010	GL11-8-ELD 10 AR	Policy/Cont ract/Fratern al	Eligibility for Dependent Dental Coverage	Initial		61.600	8ELD10 AR.pdf
		Certificate: Amendmen t, Insert Page, Endorseme nt or Rider					
Approved-Closed 10/28/2010	GL11-13-AP 10	Policy/Cont ract/Fratern al	Alternative Procedures	Initial		52.000	13AP10.pdf
		Certificate: Amendmen t, Insert Page, Endorseme nt or Rider					
Approved-Closed 10/28/2010	GL11-14-DBO 10	Policy/Cont ract/Fratern al	Dental Expense Benefits -- Orthodontics for Children/Family	Initial		63.000	14DBO10.pdf
		Certificate: Children/Family					

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Product Name:	Group Dental		
Project Name/Number:	2010 Dental Forms/GL11-4-DF 10 et al		
	Page,		
	Endorseme		
	nt or Rider		
Approved- Closed 10/28/2010	GL11-PIC 10 Rev. AR Policy/Cont Prior Plan Credit ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	59.400 PIC10 Rev AR.pdf
Approved- Closed 10/28/2010	GL12-4-DF 10 Certificate Definitions Amendmen t, Insert Page, Endorseme nt or Rider	Initial	58.000 4DF10.pdf
Approved- Closed 10/28/2010	GL12-8- ELD 10 AR Certificate Eligibility for Amendmen t, Insert Page, Endorseme nt or Rider	Initial	61.400 8ELD10 AR.pdf
Approved- Closed 10/28/2010	GL12-13- AP 10 Certificate Alternative Amendmen t, Insert Page, Endorseme nt or Rider	Initial	52.000 13AP10.pdf
Approved- Closed 10/28/2010	GL12-14- DBO 10 Certificate Dental Expense Amendmen t, Insert Page, Endorseme nt or Rider	Initial	65.000 14DBO10.pdf
Approved- Closed 10/28/2010	GL12-16- EX 10 Certificate Limitations and Amendmen Exclusions	Initial	53.000 16EX10.pdf

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TOI:	H10G Group Health - Dental	Sub-TOI:	H10G.000 Health - Dental
Product Name:	Group Dental		
Project Name/Number:	2010 Dental Forms/GL11-4-DF 10 et al		
10/28/2010	t, Insert Page, Endorseme nt or Rider		
Approved- Closed 10/28/2010	GL12-17- COB 10 AR t, Insert Page, Endorseme nt or Rider	Certificate Coordination of Benefits Initial	57.000 17COB10 AR (100%).pdf
Approved- Closed 10/28/2010	GL12-19B- PD 10 t, Insert Page, Endorseme nt or Rider	Certificate Dental Claims Amendmen Procedures for Predetermination of Benefits Initial	63.000 19BPD10.pdf
Approved- Closed 10/28/2010	GL12- CONT 10 t, Insert Page, Endorseme nt or Rider	Certificate Continuity of Coverage Initial	58.300 CONT 10.pdf
Approved- Closed 10/28/2010	GL12-PIC 10 Rev. AR t, Insert Page, Endorseme nt or Rider	Certificate Prior Plan Credit Amendmen Initial	59.800 PIC10 Rev AR.pdf
Approved- Closed 10/28/2010	AR COB EXPLANAT ORY BOOKLET	Other Coordination of Benefits Explanatory Booklet Initial	AR COB EXPLANATO RY BOOKLET.pdf f

DEFINITIONS

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

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

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

- (1) a Saturday, Sunday or holiday which is not a scheduled workday;
- (2) a paid vacation day, or other scheduled or unscheduled non-workday;
- (3) a non-medical leave of absence of 12 weeks or less, whether taken with the Group Policyholder'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.

ANNUAL ENROLLMENT PERIOD means the period in the calendar year, not to exceed 31 days, during which the Group Policyholder allows eligible Employees to purchase or make changes in their Employee or Dependent Dental Coverage.

Participation in an Annual Enrollment Period does not change Policy provisions related to the Eligibility Waiting Period or Benefit Waiting Periods; and Late Entrant Limitations will apply.

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

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

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

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

COVERAGE MONTH means that period of time:

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

at the Group Policyholder's primary place of business.

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

DEFINITIONS
(continued)

COVERED EXPENSES, for Plan 1, means expenses Incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures contained in this 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[:
 - (a)] for Type 1, 2, or 3 procedures, this Policy's Usual and Customary allowances[; and
 - (b) for Type 4 procedures, the maximum Covered Expense, as determined by the Company].

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

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

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

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

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

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

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

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

EMPLOYEE means a Full-Time Employee or Regular Part-Time Employee of the Group Policyholder.

DEFINITIONS
(continued)

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

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

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

provided the service is completed within 90 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 Group Policyholder's leave policy and the law which applies; and
- (3) does not exceed the period approved by the Group Policyholder 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 Group Policyholder:

- (1) whose employment with the Group Policyholder is the employee's principal occupation;
- (2) who is regularly scheduled to work at such occupation at least 30 hours each week;
- (3) who is not a temporary or seasonal employee;
- (4) who is a member of an employee class which is eligible for coverage under this 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 this Policy. [It can also mean the Participating Employer, if applicable.]

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

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.

DEFINITIONS
(continued)

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 this 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 this 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 Group Policyholder'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 Group Policyholder'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 this 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 Group Policyholder'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 the Company, or a qualified party selected by the Company, determines is:

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

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

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

NON-PARTICIPATING DENTIST means a Dentist who is not participating in the dental network being made available through this 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.

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

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

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

PARTICIPATING DENTIST means a Dentist who:

- (1) has signed a contract with the dental network being made available through this 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.

DEFINITIONS
(continued)

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

REGULAR PART-TIME EMPLOYEE means an employee of the [Group Policyholder or Participating Employer] who is:

- (1) regularly scheduled to work at least the number of hours shown in the Schedule of Benefits/ 20 hours each week;
- (2) a member of a class which is eligible for coverage under this Policy;
- (3) not a temporary or seasonal employee; and
- (4) a citizen of the United States or legally working in the United States.

RETIREE means a former [full-time] Employee of the [Group Policyholder or Participating Employer] who is eligible for retirement benefits.

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

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

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

**ELIGIBILITY FOR
DEPENDENT DENTAL COVERAGE**

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

- (1) legal spouse, who is not legally separated from the Covered Employee;
- (2) unmarried child less than 19 years of age; [or]
- (3) [unmarried child, who is at least 19 years of age but less than 23 years of age, if attending an accredited educational institution for the minimum number of hours required to maintain full-time student status there; or
- (4)] unmarried child age 19 years or older, who is:
 - (a) continuously unable to earn a living because of a physical or mental disability; and
 - (b) chiefly dependent upon the Covered Employee for support and maintenance. The child must be covered by the Group Policyholder's dental plan on the day before coverage would otherwise end due to his or her age. Proof of the total disability must be sent to the Company upon request. The premium will continue at the dependent rate.

"Child" includes:

- (1) a Covered Employee's natural child or legally adopted child;
- (2) a child placed with the Covered Employee for the purpose of adoption, from the date of placement;
- (3) a child for whom the Covered Employee is required by court order to provide dental coverage;
- (4) a stepchild who resides in the Covered Employee's household; and who is chiefly dependent on the Covered Employee for support; and
- (5) a foster child:
 - (a) who resides in the Covered Employee's household;
 - (b) who is chiefly dependent on the Covered Employee for support; and
 - (c) for whom the Covered Employee has assumed full parental responsibility and control.

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

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

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

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

[Any [Benefit Waiting Period(s)] [and/or] [Late Entrant Limitation Period(s)] will apply.]

An Employee must be covered for Employee Dental Coverage to cover his or her Dependents. [Dependents to be covered by this Policy must be enrolled in the same plan of benefits as the Covered Employee.]

ANNUAL ENROLLMENT PERIOD. An Employee again becomes eligible to enroll, re-enroll, or change benefit options for Dependent Dental Coverage under this Policy during the Group Policyholder's Annual Enrollment Period. [Any unsatisfied [Benefit Waiting Period(s)] [and/or] [Late Entrant Limitation Periods] will apply to coverage elected or changed during the Annual Enrollment Period.] [If an Employee terminates Dependent Dental Coverage under this Policy and subsequently re-enrolls during an Annual Enrollment Period, the Dependents will again be subject to the Policy's [Benefit Waiting Period(s)] [and/or] [Late Entrant Limitation Periods].]

EFFECTIVE DATES FOR DEPENDENT DENTAL COVERAGE

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

- (1) the first day of the Coverage Month coinciding with or next following the date the Covered Employee becomes eligible for Dependent Dental Coverage;
- (2) the first day of the Coverage Month coinciding with or next following the date the Covered Employee makes written application for Dependent Dental Coverage; and, if additional premium is required, the Employee signs:
 - (a) a payroll deduction order, if the Covered Employee pays 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 pays 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 the Covered Employee to provide dental benefits for the child, the coverage will become effective on the date stated in the court order; subject to payment of any additional premium.

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

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

within 31 days of the date the Dependent is acquired.

EXCEPTION FOR NEWBORN. If a Covered Employee acquires a newborn Dependent child, the child will be automatically covered for the first 90 days following birth. If the Covered Employee elects not to enroll the newborn child and pay any additional premium within 90 days following birth, the newborn child's coverage will terminate.

However, any [Benefit Waiting Period(s)] [and/or] [Late Entrant Limitation Periods] will be waived for such Dependent child if the Covered Employee elects 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.

ALTERNATIVE PROCEDURES

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

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

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

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

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

DENTAL EXPENSE BENEFITS
[ORTHODONTICS FOR CHILDREN/FAMILY ORTHODONTICS]

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

- (1) [begins/receives] Orthodontic Treatment while covered for Type 4 services (Orthodontics), under this Policy; [and]
- (2) incurs [initial] Covered Expenses for Orthodontic Treatment after any Benefit Waiting Period or Late Entrant Limitation Period is satisfied};and
- (3) [for a covered Dependent child,]has the orthodontic appliance initially installed prior to age 19}.

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

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

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

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

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

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

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

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

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

LIMITATIONS AND EXCLUSIONS

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

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

LIMITATIONS AND EXCLUSIONS
(Continued)

- (9) except as specifically shown in the List of Covered Dental Procedures included in this 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 this Policy that are related to the dental implant.
- (10) 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.
- (11) orthognathic recording, orthognathic surgery, osteoplasty, osteotomy, LeFort procedures, stomatoplasty, computed tomography imaging (CT scans), cone beam, or magnetic resonance imaging (MRIs).
- (12) initial placement of any prosthetic appliance; unless such placement is needed to replace one or more natural teeth extracted while the Covered Person is covered under this Policy, subject to the Prior Plan Credit provision [and the Continuity of Coverage provision], if included in this Policy. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth.
- (13) the adjustment, recementation, reline, rebase, replacement or repair of cast restorations, crowns and prostheses, within 6 months of the completion of the service.
- (14) 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 the Covered Person is covered under this Policy, it will be a Covered Expense. If services related to the Injury are covered by the Covered Person's group medical plan, those charges should be submitted to the medical plan first.
- (15) specialized procedures, including:
 - (a) precision or semi-precision attachments;
 - (b) precious metals for removable appliances;
 - (c) overlays and overdentures; or
 - (d) personalization or characterization.
- (16) 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 this 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.
- (17) appliances, restorations or procedures, or their modifications, that:
 - (a) alter vertical dimension;
 - (b) restore or maintain occlusion or for occlusal adjustment or equilibration;
 - (c) stabilize teeth;
 - (d) replace tooth structure lost as a result of erosion, abfraction, abrasion or attrition;
 - (e) surgically or non-surgically treat disturbances of the temporomandibular joint (TMJ), or other craniomandibular or temporomandibular disorders, except as required by law or as specifically shown in the List of Covered Dental Procedures; or
 - (f) involve elimination of undercuts, box form, or concave irregularity caused in the preparation.

LIMITATIONS AND EXCLUSIONS
(Continued)

- (18) charges for services provided by:
 - (a) an ambulatory surgical facility;
 - (b) a hospital;
 - (c) any other facility; or
 - (d) an anesthesiologist.

- (19) except as specifically shown in the List of Covered Dental Procedures included in this Policy, analgesia, sedation, hypnosis or acupuncture, for anxiety or apprehension.

- (20) any medications administered outside the Dentist's office or for prescription drugs.

- (21) except as specifically shown in the List of Covered Dental Procedures included in this 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.

- (22) itemized or separated charges for dental services, supplies or materials when those services, supplies and materials may be combined into a single, more comprehensive procedure payable under this Policy. This also includes itemized charges which are routinely included in the Dentist's charge for the primary service, such as:
 - (a) sterilization or asepsis charges;
 - (b) a charge for local anesthesia 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 this Policy.

- (23) charges for which the Covered Person is not liable, or which would not have been made had no coverage been in force.

- (24) a Covered Person's dental Injury or condition:
 - (a) for which he or she is eligible for benefits under Workers' Compensation or any similar law;
 - (b) arising out of, or in the course of, work for wage or profit; or
 - (c) sustained while performing military service.

- (25) services received for dental conditions caused directly or indirectly by:
 - (a) war or an act of war;
 - (b) intentionally self-inflicted Injury;
 - (c) engaging in an illegal occupation;
 - (d) commission or attempt to commit a felony; or
 - (e) a Covered Person's active participation in a riot.

LIMITATIONS AND EXCLUSIONS
(Continued)

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

COORDINATION OF DENTAL EXPENSE BENEFITS

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

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

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

If a Covered Person is covered by more than one Plan, he or she should file all claims with each plan.

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

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

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

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

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

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

"Claimant" means the Covered Person for whom claim is made.

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

DENTAL CLAIM PROCEDURE
for
PREDETERMINATION OF BENEFITS

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

To use this procedure:

- (1) the Covered Employee should request a claim form and take it to the Dentist;
- (2) the Dentist will list the proposed procedures and fees on the claim form and return it to the Company 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.

CONTINUITY OF COVERAGE

ELIGIBILITY. A Covered Person 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) the Employee:
 - (a) is covered under a previous employer's group dental plan within 31 days before Dental Expense Benefits under this Policy take effect for such Employee and coverage with the group dental plan terminates; and
 - (b) immediately becomes covered under this dental plan on the earliest day that the Dental Expense Benefits under this Policy can take effect.
- (2) the Employee's Dependent:
 - (a) is covered under an employer's group dental plan within 31 days before Dental Expense Benefits under this Policy take 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 this Policy can take effect; and
 - (c) the Employee is covered for Group Dental Expense Benefits under this Policy.

EFFECT OF CONTINUITY OF COVERAGE ON BENEFITS. If this provision applies, then the Covered Person's Dental Expense Benefits will be payable as follows.

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

PRIOR PLAN CREDIT

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

- (1) the Schedule of Benefits shows that the Prior Plan Credit provision applies;
- (2) the Dental Expense Benefits under this Policy replace a Prior Plan; and
- (3) the Covered Person immediately becomes covered under this dental plan on the day the [Group Policyholder's/Participating Employer's], affiliate's, or acquired company's Dental Expense Benefits under this Policy take effect.

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

- {(1) Any amounts used to satisfy the Covered Person's Deductible under the Prior Plan will be credited toward the satisfaction of his or her Deductible under this Policy; provided:
 - (a) the expenses would be Covered Expenses under this Policy;
 - (b) the expenses are incurred during the same [Calendar/Policy/Plan] Year in which Dental Expense Benefits under this Policy take effect; and
 - (c) the Covered Person sends the Company a claim worksheet explaining the benefits paid by the Prior Plan.}
- {(2) Benefits paid by the Prior Plan in the same [Calendar/Policy/Plan] Year as this Policy takes effect will be applied towards the [Calendar/Policy/Plan] Year Maximum under this Policy.}
- [(3) Orthodontia Benefits paid by the Prior Plan will be applied toward the Lifetime Maximum for Type 4 services (Child Orthodontia) under this Policy.]
- [(4) The Covered Person's continuous months of coverage under the Prior Plan just before it terminated will count toward this Policy's Benefit Waiting Period for Type 2 Procedures (Basic Care) [or Type 3 services (Major Care)], if any.
- [(5) The Covered Person's continuous months of coverage under the Prior Plan just before it terminated will also count toward any Benefit Waiting Period for Type 4 services (Child Orthodontia) under this Policy; but only if both the Prior Plan and this Policy provide orthodontia benefits.]
- [(6) Expense that the Covered 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 this Policy or under the Prior Plan;
 - (b) the replacement would have been covered under the Prior Plan; and
 - (c) the extracted teeth are not third molars (wisdom teeth).]

DEFINITION

"Prior Plan" means:

- (1) the [Group Policyholder's/Participating Employer's] Prior Group Dental Plan; or
- (2) the Prior Dental Plan of an affiliate or an entity acquired by the Group Policyholder after the Policy's effective date;

which this Policy replaced:

- (1) within 1 day of the Prior Plan's termination date; or
- (2) within 60 days of the Prior Plan's termination date, if the Employer has more than 15 Covered Employees under this Policy on its effective date.

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.

ANNUAL ENROLLMENT PERIOD means the period in the calendar year, not to exceed 31 days, during which the Employer allows eligible Employees to purchase or make changes in their Employee or Dependent Dental Coverage.

Participation in an Annual Enrollment Period does not change Policy provisions related to the Eligibility Waiting Period or Benefit Waiting Periods; and Late Entrant Limitations will apply.

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

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

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

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

COVERAGE MONTH means that period of time:

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

at the Group Policyholder's primary place of business.

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

DEFINITIONS
(continued)

COVERED EXPENSES, for Plan 1, 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:
 - (a) for Type 1, 2, or 3 procedures, the Policy's Usual and Customary allowances[; and
 - (b) for Type 4 procedures, the maximum Covered Expense, as determined by the Company].

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

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

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

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

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

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

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

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

EMPLOYEE means a Full-Time Employee or Regular Part-Time Employee of the Employer.

DEFINITIONS
(continued)

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 90 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 30 hours each week;
- (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. [It can also mean the Participating Employer, if applicable.]

INJURY means damage to a Covered Person's mouth, teeth, appliance, or dental prosthesis due to an accident that occurs while he or she is covered by 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.

DEFINITIONS
(continued)

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 the Company, or a qualified party selected by the Company, determines is:

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

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

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

NON-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.

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

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

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

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.

DEFINITIONS
(continued)

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

REGULAR PART-TIME EMPLOYEE means an employee of the Employer who is:

- (1) regularly scheduled to work at least the number of hours shown in the Schedule of Benefits/ 20 hours each week;
- (2) a member of a class which is eligible for coverage under the Policy;
- (3) not a temporary or seasonal employee; and
- (4) a citizen of the United States or legally working in the United States.

RETIREE means a former [Full-Time] Employee of the [Group Policyholder/Participating Employer/Employer] who is eligible for retirement benefits.

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

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

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

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

**ELIGIBILITY FOR
DEPENDENT DENTAL COVERAGE**

DEPENDENT means a person who is your:

- (1) legal spouse, who is not legally separated from you;
- (2) unmarried child less than 19 years of age; [or]
- (3) [unmarried child, who is at least 19 years of age but less than 23 years of age, if attending an accredited educational institution for the minimum number of hours required to maintain full-time student status there; or
- (4)] unmarried child age 19 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 upon request. The premium will continue at the dependent rate.

"Child" includes:

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

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

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

You again become eligible to enroll for Dependent Dental Coverage under the Policy:

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

[Any [Benefit Waiting Period(s)] [and/or] [Late Entrant Limitation Period(s)] will apply.]

You must be covered for Employee Dental Coverage to cover your Dependents. [Dependents to be covered by the Policy must be enrolled in the same plan of benefits as you.]

ANNUAL 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 Annual Enrollment Period. [Any unsatisfied [Benefit Waiting Period(s)] [and/or] [Late Entrant Limitation Periods] will apply to coverage elected or changed during the Annual Enrollment Period.] [If you terminate Dependent Dental Coverage under the Policy and subsequently re-enroll during an Annual Enrollment Period, your Dependents will again be subject to the Policy's [Benefit Waiting Period(s)] [and/or] [Late Entrant Limitation Periods].]

EFFECTIVE DATES FOR DEPENDENT DENTAL COVERAGE

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

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

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

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

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

within 31 days of the date the Dependent is acquired.

EXCEPTION FOR NEWBORN. If you acquire a newborn Dependent child, the child will be automatically covered for the first 90 days following birth. If you elect not to enroll the newborn child and pay any additional premium within 90 days following birth, the newborn child's coverage will terminate.

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

ALTERNATIVE PROCEDURES

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

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

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

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

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

DENTAL EXPENSE BENEFITS
[ORTHODONTICS FOR CHILDREN/FAMILY ORTHODONTICS]

BENEFITS FOR TYPE 4 SERVICES. The Company will pay Dental Expense Benefits for Orthodontic Treatment if [a covered Dependent child/you or your Dependent]:

- (1) [begins/receives] Orthodontic Treatment while covered for Type 4 services (Orthodontics), under the Policy; [and]
- (2) incurs [initial] Covered Expenses for Orthodontic Treatment after any Benefit Waiting Period or Late Entrant Limitation Period is satisfied}; and
- (3) [for a covered Dependent child,]has the orthodontic appliance initially installed prior to age 19}.

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

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

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

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

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

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

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

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

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

LIMITATIONS AND EXCLUSIONS

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

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

LIMITATIONS AND EXCLUSIONS
(Continued)

- (9) 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.
- (10) 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.
- (11) orthognathic recording, orthognathic surgery, osteoplasty, osteotomy, LeFort procedures, stomatoplasty, computed tomography imaging (CT scans), cone beam, or magnetic resonance imaging (MRIs).
- (12) 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.
- (13) the adjustment, recementation, reline, rebase, replacement or repair of cast restorations, crowns and prostheses, within 6 months of the completion of the service.
- (14) 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.
- (15) specialized procedures, including:
 - (a) precision or semi-precision attachments;
 - (b) precious metals for removable appliances;
 - (c) overlays and overdentures; or
 - (d) personalization or characterization.
- (16) 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.
- (17) appliances, restorations or procedures, or their modifications, that:
 - (a) alter vertical dimension;
 - (b) restore or maintain occlusion or for occlusal adjustment or equilibration;
 - (c) stabilize teeth;
 - (d) replace tooth structure lost as a result of erosion, abfraction, abrasion or attrition;
 - (e) surgically or non-surgically treat disturbances of the temporomandibular joint (TMJ), or other craniomandibular or temporomandibular disorders, except as required by law or as specifically shown in the List of Covered Dental Procedures; or
 - (f) involve elimination of undercuts, box form, or concave irregularity caused in the preparation.

LIMITATIONS AND EXCLUSIONS
(Continued)

- (18) charges for services provided by:
 - (a) an ambulatory surgical facility;
 - (b) a hospital;
 - (c) any other facility; or
 - (d) an anesthesiologist.

- (19) except as specifically shown in the List of Covered Dental Procedures included in the Policy, analgesia, sedation, hypnosis or acupuncture, for anxiety or apprehension.

- (20) any medications administered outside the Dentist's office or for prescription drugs.

- (21) 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.

- (22) 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.

- (23) charges for which you are not liable, or which would not have been made had no coverage been in force.

- (24) 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.

- (25) services received for dental conditions caused directly or indirectly by:
 - (a) war or an act of war;
 - (b) intentionally self-inflicted Injury;
 - (c) engaging in an illegal occupation;
 - (d) commission or attempt to commit a felony; or
 - (e) your or your Dependent's active participation in a riot.

LIMITATIONS AND EXCLUSIONS
(Continued)

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

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.

If you are covered by more than one Plan, you should file all your claims with each 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.

DENTAL CLAIM PROCEDURE
for
PREDETERMINATION OF BENEFITS

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

To use this procedure:

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

CONTINUITY OF COVERAGE

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

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

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

- {(1) Any amounts used to satisfy that person's Deductible under the prior plan will be credited toward the satisfaction of his or her Deductible under the Policy; provided:
 - (a) the expenses would be Covered Expenses under the Policy;
 - (b) the expenses are incurred during the same [Calendar/Policy/Plan] Year in which Dental Expense Benefits under the Policy take effect; and
 - (c) you send the Company a claim worksheet explaining the benefits paid by the prior plan.}
- {(2) Benefits paid by the prior plan in the same [Calendar/Policy/Plan] Year as the Policy takes effect will be applied towards the [Calendar/Policy/Plan] Year Maximum under the Policy.}
- [(3) Orthodontia Benefits paid by the prior plan will be applied toward the Lifetime Maximum for Type 4 services (Child Orthodontia) under the Policy.]
- [(4) That person's continuous months of coverage under the prior plan just before it terminated will count toward the Policy's Benefit Waiting Period for Type 2 Procedures (Basic Care) [or Type 3 services (Major Care)], if any.
- [(5) That person's continuous months of coverage under the prior plan just before it terminated will also count toward any Benefit Waiting Period for Type 4 services (Child Orthodontia) under the Policy; but only if both the prior group dental plan and the Policy provide orthodontia benefits.]
- [(6) 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).]

PRIOR PLAN CREDIT

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

- (1) the Schedule of Benefits shows that the Prior Plan Credit provision applies;
- (2) the Dental Expense Benefits under this Policy replace a Prior Plan; and
- (3) the Covered Person immediately becomes covered under this dental plan on the day the Employer's, affiliate's, or acquired company's Dental Expense Benefits under the Policy take effect.

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

- {(1) Any amounts used to satisfy that person's Deductible under the Prior Plan will be credited toward the satisfaction of his or her Deductible under the Policy; provided:
 - (a) the expenses would be Covered Expenses under the Policy;
 - (b) the expenses are incurred during the same [Calendar/Policy/Plan] Year in which Dental Expense Benefits under the Policy take effect; and
 - (c) you send the Company a claim worksheet explaining the benefits paid by the Prior Plan.}
- {(2) Benefits paid by the Prior Plan in the same [Calendar/Policy/Plan] Year as the Policy takes effect will be applied towards the [Calendar/Policy/Plan] Year Maximum under the Policy.}
- [(3) Orthodontia Benefits paid by the Prior Plan will be applied toward the Lifetime Maximum for Type 4 services (Child Orthodontia) under the Policy.]
- [(4) That person's continuous months of coverage under the Prior Plan just before it terminated will count toward the Policy's Benefit Waiting Period for Type 2 Procedures (Basic Care) [or Type 3 services (Major Care)], if any.
- [(5) Your or your Dependent child's continuous months of coverage under the Prior Plan just before it terminated will also count toward any Benefit Waiting Period for Type 4 services (Child Orthodontia) under the Policy; but only if both the Prior Plan and the Policy provide orthodontia benefits.]
- [(6) 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 Plan;
 - (b) the replacement would have been covered under the Prior Plan; and
 - (c) the extracted teeth are not third molars (wisdom teeth).]

DEFINITION

"Prior Plan" means:

- (1) your Employer's Prior Group Dental Plan; or
- (2) the Prior Dental Plan of an affiliate or an entity acquired by your Employer after the Policy's effective date;

which the Policy replaced:

- (1) within 1 day of the Prior Plan's termination date; or
- (2) within 60 days of the Prior Plan's termination date, if your Employer has more than 15 Covered Employees under the Policy on its effective date.

CONSUMER EXPLANATORY BOOKLET COORDINATION OF BENEFITS

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the "primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state's COB rules will always be primary.

When This Plan is Primary

If you or a family member are covered under another plan in addition to this one, we will be primary when:

- The claim is for **your own** health care expenses, unless you are covered by Medicare and both you and your spouse are retired.
- The claim is for **your spouse**, who is covered by Medicare, and you are not both retired.
- The claim is for the health care expenses of **your child** who is covered by this plan; and

you are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday (the "birthday rule");

you are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses; or

there is no court decree, but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

**CONSUMER EXPLANATORY BOOKLET
COORDINATION OF BENEFITS
(Continued)**

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits in accordance with the terms of your contract, just as if you had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary

We will be secondary whenever the rules do not require us to be primary.

How We Pay Claims When We Are Secondary

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An “allowable expense” is a health care expense covered by one of the plans, including copayments, coinsurance and deductibles.

- If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) usually have contracts with their providers.
- We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We may reduce our payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid do not exceed the total allowable expense for your claim. We will credit any amount we would have paid in the absence of your other health care coverage toward our own plan deductible.
- If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.
- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

Questions About Coordination of Benefits?

Contact Your State Insurance Department:

ARKANSAS INSURANCE DEPARTMENT

1200 WEST THIRD STREET
LITTLE ROCK, AR 72201

1-800-852-5494

SERFF Tracking Number: JEPT-126868546 State: Arkansas
 Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 47095
 Company Tracking Number: GL11-4-DF 10
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Dental
 Project Name/Number: 2010 Dental Forms/GL11-4-DF 10 et al

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: 09202010 AR Dental Read Cert.pdf	Approved-Closed	10/28/2010

	Item Status:	Status Date:
Satisfied - Item: Application Comments: The GL2-APP.09/02 was approved 05/04/2007.	Approved-Closed	10/28/2010

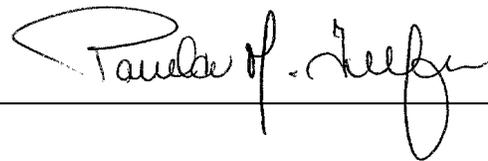
	Item Status:	Status Date:
Satisfied - Item: Appendix of Variability Comments: Attachment: 09202010 AR Appendix of Variability.pdf	Approved-Closed	10/28/2010

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

READABILITY CERTIFICATION

This is to certify that the forms shown below have achieved the indicated Flesch Reading Ease Score.

<u>FORM NO.</u>	<u>FLESCH SCORE</u>
GL11-4-DF 10	58.0
GL11-8-ELD 10 AR	61.6
GL11-13-AP 10	52.0
GL11-14-DBO 10	63.0
GL11-16-EX 10	52.0
GL11-17-COB 10 AR	57.0
GL11-19B-PD 10	63.0
GL11-CONT 10	57.9
GL11-PIC 10 Rev. AR	59.4
GL12-4-DF 10	58.0
GL12-8-ELD 10 AR	61.4
GL12-13-AP 10	52.0
GL12-14-DBO 10	65.0
GL12-16-EX 10	53.0
GL12-17-COB 10 AR	57.0
GL12-19B-PD 10	63.0
GL12-CONT 10	58.3
GL12-PIC 10 Rev. AR	59.8



(An Officer of the Company)
Pamela M. Telfer
Assistant Vice President, Product Compliance and State
Filing

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

APPENDIX OF VARIABILITY

For Forms:

GL11-4-DF 10
GL11-8-ELD 10 AR
GL11-13-AP 10
GL11-14-DBO 10
GL11-16-EX 10
GL11-17-COB 10 AR
GL11-19B-PD 10
GL11-CONT 10
GL11-PIC 10 Rev. AR

GL12-4-DF 10
GL12-8-ELD 10 AR
GL12-13-AP 10
GL12-14-DBO 10
GL12-16-EX 10
GL12-17-COB 10 AR
GL12-19B-PD 10
GL12-CONT 10
GL12-PIC 10 Rev. AR

The above forms are for use with Group Policy Series GL11 and Group Certificate Series GL12.

Statement of Variable Material. Variable material is denoted in the forms by underlining or bracketing. The text for the certificate is expressed in second person (you/your) language. The variability indicated in this Memorandum applies to both the policy version and certificate version of forms, unless otherwise indicated. Any alternate variations included in this memorandum that are in third person for the policy would be expressed in second person in the certificate. The following variability is requested.

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1. **DEFINITIONS.** Forms GL11-4-DF 10 and GL12-4-DF 10

These forms contain the standard definitions. We request that underlined references to Covered Employees or Employees be variable to accommodate retiree, associate, member, or other language requested by the Policyholder. We also request variable filing of the following bracketed definitions:

Active Work, so that it can be omitted when not applicable, or adapted to atypical worksites and schedules (such as telecommuters, academic years, or union hour banks); so that the exception for non-medical leaves of absence in item (3) may range from 2 weeks to 60 months, or omitted; and so the references to "Military Leave" and "Family Medical Leave" may be omitted for groups that are not subject to those federal requirements.

If the group includes atypical work sites, the Actively at Work definition may include the following item: an alternate work site at the direction of/approved by the Employer.

If the group includes teachers, an item may be added to the days considered Actively at Work to state: a school/academic break or school/academic vacation. An Active Member definition may be included to mean a member of the Group Policyholder who is employed as a teacher with a workload of at least (%) full-time during the teacher contract year. (%= 30-90)

If members are included, Active Member may be included to mean a member in good standing with the Group Policyholder/a member who has accumulated at least # contribution hours in a contribution quarter or Hour Bank/a member who has worked # hours in a work quarter, work period, eligibility quarter, or eligibility period or # hours in a Hour Bank. (#= 20-2080 depending on the accumulation period).

Annual Enrollment Period, so that it can be omitted when not applicable, or so that it can be changed to accommodate retirees, associates, or other language as requested by the Group Policyholder; and so that the 31-day limitation can vary up to 60 days. Benefit Waiting Periods and/or Late Entrant Limitations can be omitted when not applicable.

Benefit Waiting Period, so it can be omitted when not applicable.

Change in Family Status, so additional status changes can be added by group request or it can be omitted when not applicable. References to Section 125 Plans can be changed to reflect the appropriate plan for the group, such as Flexible Benefit Plan, Cafeteria Plan, or Flexible Spending Account.

Company, so that the Group Insurance Service Office and address can be updated if necessary.

Coverage Month, so that it may be amended to accommodate group-specific needs.

Covered Employee, so that underlined references to Covered Employees or Employees be variable to accommodate retiree, associate, member, or other language requested by the Policyholder.

Covered Expenses, so that one of the alternate definitions for Covered Expenses can be used, depending on which dental plan is selected. The underlined text can be used when more than one Plan or type of service is provided under a policy. The bracketed text can be removed when that type of service is not elected.

a. **Regular Indemnity (Standard Plan – Non PPO):**

COVERED EXPENSES, for Plan 1, means expenses which:

- (1) are Incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures contained in this Policy; and
- (2) do not exceed this Policy's Usual and Customary allowances.

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

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b. PPO Plan:

COVERED EXPENSES, for Plan 1, means expenses Incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures contained in this 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[:
 - (a)] for Type 1, 2, or 3 procedures, this Policy's Usual and Customary allowances[; and
 - (b) for Type 4 procedures, the maximum Covered Expense, as determined by the Company].

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

c. Scheduled Indemnity Plan:

COVERED EXPENSES, for Plan 1, means expenses which:

- (1) are Incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures contained in this Policy; and
- (2) do not exceed:
 - (a) the Dentist's normal charge for a procedure; or
 - (b) the scheduled fee contained in this Policy; whichever is less.

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

d. PPO Plan with Schedule for Out-of-Network, except U & C for Type 1, 2 or 3:

COVERED EXPENSES, for Plan 1, means expenses Incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures contained in this 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[:
 - (a)] for Type 1, 2 or 3 procedures, this Policy's Usual and Customary allowances[; and
 - (b) for all other covered procedures:
 - i) the Dentist's normal charge for a procedure; or
 - ii) the scheduled fee contained in this Policy; whichever is less].

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

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e. PPO Plan with Schedule for Out-of-Network:

COVERED EXPENSES, for Plan 1, means expenses Incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures contained in this 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:
 - (a) the Dentist's normal charge for a procedure; or
 - (b) the scheduled fee contained in this Policy; whichever is less.

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

f. Maximum Allowable Charge (MAC) PPO Plan:

COVERED EXPENSES, for Plan 1, means expenses Incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures contained in this 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 Maximum Allowable Charge. The Maximum Allowable Charge is:
 - (a) the Dentist's normal charge for a procedure; or
 - (b) the lowest negotiated fee allowed by the dental network contracts with Participating Dentists; or, in the event there is no negotiated fee, the 50th percentile of this Policy's Usual and Customary allowances; whichever is less.

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

g. Scheduled Indemnity Plan, except U & C for Type 1, 2 or 3:

COVERED EXPENSES, for Plan 1, means expenses Incurred for Necessary Dental Procedures shown on the List of Covered Dental Procedures contained in this Policy. Covered Expenses do not exceed[:

- (1) for Type 1, 2 or 3 procedures, this Policy's Usual and Customary allowances]; and
- (2) for all other covered procedures:
 - (a) the Dentist's normal charge for a procedure; or
 - (b) the scheduled fee contained in this Policy; whichever is less].

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

Covered Person, so that it can be expanded (to include members or partners, for instance) by group request.

Day or Date, so that it may be amended to accommodate group-specific needs.

Dependent and Dependent Dental Coverage, so that they can be omitted if not applicable.

The Lincoln National Life Insurance Company

Eligibility Waiting Period, so that it can be reworded to accommodate non-continuous and other non-standard waiting periods, or omitted when not applicable.

Employee, so that either Full-Time Employees or Full-Time Employees or Regular Part-Time Employees can be included. If needed to accommodate group-specific needs, the definition can be amended.

Expenses Incurred, so that the underlined number may range from 31 to 120, with 90 being the standard.

Family or Medical Leave definition is variable, so that it can be reworded to reflect any change in federal requirements; or, reference may be omitted for groups that are not subject to those federal requirements.

Full-Time Employee, so that eligibility can be based on working 15 to 40 hours per week (or hours over some longer period, such as a union hour bank or teaching schedule may require), and to amend the definition as needed to accommodate group-specific needs. In the event only full-time employees are covered under the policy, the definition of Full-Time Employee becomes the definition of Employee.

Group Policyholder, so that the second sentence may be omitted if not applicable.

Late Entrant, so that the underlined number of days can be longer than 31, if requested, and so that the definition can be omitted if not applicable.

Late Entrant Limitation Period, so that the definition can be omitted if not applicable.

Military Leave, so that it can be reworded to reflect any change in federal requirements; or, reference may be omitted for groups that are not subject to those federal requirements.

Non-Participating Dentist, so that this definition can be omitted when not applicable.

Open Enrollment Period, so that it can be omitted when not applicable, or so that it can be changed to accommodate retirees, associates, or other language as requested by the Group Policyholder; and so that the 31-day limitation can vary up to 60 days. Benefit Waiting Periods can be omitted when not applicable.

Orthodontic Treatment, so that this definition can be omitted when not applicable.

Participating Dentist, so that this definition can be omitted when not applicable.

Payroll Period, so that this definition can be omitted when not applicable.

Regular Part-Time Employee, so that the enumerated conditions may be altered or omitted by policyholder request; so that the "Group Policyholder" or "Participating Employer" language may be omitted or included as applicable; so that the underlined number of hours may be changed to accommodate a group's request; and so that the entire definition may be omitted when not applicable.

Retiree, so that the definition may be altered by policyholder request; so that the bracketed "full-time" be omitted when not applicable; so that the "Group Policyholder" or "Participating Employer" language may be omitted or included as applicable; and so that the entire definition may be omitted when not applicable.

Usual and Customary, so that the Group Insurance Service Office can be updated if necessary; and so that the entire definition can be omitted when not applicable.

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2. ELIGIBILITY FOR DEPENDENT DENTAL COVERAGE. Forms GL11-8-ELD 10 AR and GL12-8-ELD 10 AR

These forms contain the definitions, eligibility, effective date, and other provisions for Dependents. We request that underlined references to Covered Employees or Employees be variable to accommodate retiree, associate, member, or other language requested by the Policyholder. We request that the underlined ages be variable. The ages will never be lower than the dependent ages required by state law, but may be higher. Child dependent eligibility can be to a specified age or to a specified period of time, such as the end of the calendar year following the attainment of a specified age or the first day of the calendar year next following the attainment of a specified age.

There is an alternate definition of the bracketed definition of a DEPENDENT. That definition will read:

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

- (1) legal spouse, who is not legally separated from the Covered Employee;
- (2) child less than 26 years of age; or
- (3) 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 the Covered Employee for support and maintenance.The child must be covered by the Group Policyholder's dental plan on the day before coverage would otherwise end due to his or her age. Proof of the total disability must be sent to the Company upon request. The premium will continue at the dependent rate.

"Child" includes:

- (1) a Covered Employee's natural child, legally adopted child, or stepchild;
- (2) a child placed with the Covered Employee for the purpose of adoption, from the date of placement;
- (3) a child for whom the Covered Employee is required by court order to provide dental coverage; and
- (4) a foster child for whom the Covered Employee has assumed full parental responsibility and control.

We also request that the underlined time periods under the Eligibility and Effective Dates provisions be variable so coverage can begin on the day, day following, first of the month following, or any other day following the events listed.

The bracketed language in the second and third paragraphs under the Eligibility provision is to be omitted when not applicable, as is the Annual Enrollment Period paragraph. The number of days is variable to the extent that it can be increased but not decreased. We request variable filing of the underlined Annual Enrollment Period language, so that Open Enrollment can be substituted upon special request.

The bracketed references to Benefit Waiting Periods and/or Late Entrant Limitation Periods may be omitted when not applicable.

We request variable filing of the Effective Date language, so that:

1. coverage can begin on the day, day following, first of month following, or any other specified day following the events listed;
2. reference to application or payroll deduction order can be omitted, when enrollment is automatic (as for noncontributory or replacement plans);
3. reference to Late Entrant can be omitted, when not required;
4. references to Section 125 Plans can be changed to reflect the appropriate plan for the group, such as Flexible Benefit Plan, Cafeteria Plan, or Flexible Spending Account; and
5. the language may be altered to accommodate special group requests.

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We request variable filing of the underlined Section 125 language in the New Dependents section to reflect the appropriate plan for the group, such as Flexible Benefit Plan, Cafeteria Plan, or Flexible Spending Account.

The bracketed paragraph under the Exception provision may be omitted for plans with no Benefit Waiting Period(s) and/or Late Entrant Limitation Periods.

3. ALTERNATIVE PROCEDURES. Form GL11-13-AP 10 and GL12-13-AP 10

These forms explain the Alternative Procedures provision. No variability is requested for this provision.

4. DENTAL EXPENSE BENEFITS—ORTHODONTICS FOR CHILDREN/FAMILY ORTHODONTICS. Forms GL11-14-DBO 10 and GL12-14-DBO 10

These forms are Dental Expense Benefits insert pages for Type 4 services (Orthodontia). We request that the bracketed language in the form title be filed as omit-only variable in order to distinguish between plans that provide orthodontic coverage for children only, and those that provide orthodontic coverage for all covered family members. Similarly, we request that the underlined "Covered Person" language be filed as variable throughout, so that it may be substituted with "covered Dependent child" for child-only orthodontic coverage.

The bracketed terms "begins" and "initial" will be the standard wording for orthodontic benefits, but we request variable filing of them in order to accommodate plans in which a Covered Person is not required to be banded while covered under our policy. For such plans, the word "begins" will be substituted with "receives," and the word "initial" will be deleted.

Item (3) will be included if requested by the Group Policyholder. The bracketed "[for a covered Dependent child,]" will be included if family coverage is provided and Item (3) only applies to covered Dependent children.

The bracketed Lifetime Maximum sentence and the Benefit Waiting Period and Late Entrant Limitation Period paragraphs will be omitted when not applicable.

5. LIMITATIONS AND EXCLUSIONS. Forms GL11-16-EX 10 and GL12-16-EX 10

These forms list the Policy Limitations and Exclusions. The forms and phrases that are bracketed are material that may be omitted when not applicable, but not reworded. Also, the underlined term "Dependent child" is variable, so that it can be changed to "Covered Person," "Covered Employee," or other similar term, as needed or as requested by a group.

For a plan that covers Type 1, 2, and 3 services only, exclusion #5 will read, "Orthodontic (Type 4) services." When used with a plan that covers Type 1 and 2 services only, the exclusion will read, "Major (Type 3) services or Orthodontic (Type 4) services." The bracketed "which begins" will be used for plans that require the Covered Person to be banded while covered under our Policy (standard wording). "Received" will be used for plans that do not require banding while covered under our Policy. The bracketed "due to attainment of the maximum age, or for any other reason" may be omitted when not applicable.

6. COORDINATION OF BENEFITS. Forms GL11-17-COB 10 AR and GL12-17-COB 10 AR

These forms define the terms used for Coordination of Benefits.

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7. DENTAL CLAIMS PROCEDURE for PREDETERMINATION OF BENEFITS. Forms GL11-19B PD 10 and GL12-19B-PD 10

These forms describe to the procedure to follow to request a predetermination of benefits in excess of the specified amount. The amount can range from \$250 to \$500. We request the reference to Covered Employee to be variable to accommodate retiree, associate, member, or other language requested by the Group Policyholder

8. CONTINUITY OF COVERAGE. Forms GL11-CONT 10 and GL12-CONT 10

These forms permit persons to continue coverage if enrolled in another employer's group dental plan within a specified number of days (31 days is the standard, but this may vary) before Dental Expense Benefits under this Policy take effect. We request that the following bracketed material be filed as variable:

- (1) Calendar Year, so that it can be changed to Policy or Plan Year upon request; and
- (2) the bracketed items in the Effect on Prior Plan Credit paragraph, so that they may be omitted when the plan does not offer those benefits.

9. PRIOR PLAN CREDIT. Forms GL11-PIC 10 Rev. AR and GL12-PIC 10 Rev. AR

These forms explain the Prior Plan Credit provision, used when our plan replaces an existing dental plan. We request variable filing of the underlined "on the day," so that coverage can begin on the day, day following, first of month following, or any other specified day. We request that the following bracketed material be filed as variable:

- (1) Group Policyholder, so that it can be changed to Participating Employer, as needed;
- (2) Calendar Year, so that it can be changed to Policy or Plan Year upon request; and
- (3) the bracketed items in the Effect on Prior Plan Credit paragraph, so that they may be omitted when the plan does not offer those benefits.