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

CERTIFIES THAT Group Policy No. 00001D034406 has been issued to

United Cerebral Palsy Association of Greater Cleveland, Inc.
(The Group Policyholder)

The issue date of the Policy is May 1, 2017.

This certificate supersedes and replaces any previously issued certificate with an effective date of May 1, 2017.

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

Certificate of Insurance for Class 2

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

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

NOTICE: If you or your family members are covered by more than one dental plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific dentists, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the Coordination of Dental Expense Benefits and Order of Benefit Determination Rules sections of this Certificate. Compare these rules with the rules of any other plan that covers you or your family.

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686-1526.

Dennis R Glass
PRESIDENT

**CERTIFICATE OF GROUP
DENTAL INSURANCE**

United Cerebral Palsy Association of Greater Cleveland, Inc.
00001D034406
SCHEDULE OF BENEFITS

ELIGIBLE CLASS

Class 2 All Full-Time Non-Exempt Employees

DENTAL PREFERRED PROVIDER ORGANIZATION (PPO).
This plan is designed to provide high quality dental care while managing the cost of the care. To do this, you are encouraged to seek dental care from Dentists who have signed a contract with the dental network being offered by the Policy. These Dentists are called Participating Dentists.

Use of a Participating Dentist is voluntary. You may receive treatment from any Dentist you choose. And you are free to change Dentists at any time. But, your out-of-pocket expenses for covered services are usually lower when the services are provided by a Participating Dentist.

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

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

OPEN ENROLLMENT PERIOD: There will be an Open Enrollment Period for one month each year beginning April 1st and ending April 30th, for eligible Employees and their Dependents to enroll for Dental Insurance. Late Entrant Limitations will be waived for anyone enrolling during this Open Enrollment Period. Dental Insurance will become effective on the May 1st following the Open Enrollment period.

United Cerebral Palsy Association of Greater Cleveland, Inc.
00001D034406
SCHEDULE OF BENEFITS
For
Class 2 - All Full-Time Non-Exempt Employees

MINIMUM HOURS: 30 hours per week

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

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

Benefit Waiting Period:

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

Late Entrant Limitation (when applicable):

Type 2 Procedures:	12 Months
Type 3 Procedures:	12 Months
Type 4 Procedures:	12 Months

United Cerebral Palsy Association of Greater Cleveland, Inc.
00001D034406
SCHEDULE OF BENEFITS
(Continued)
For
Class 2

DENTAL BENEFITS

	PPO PLAN In-Network Services	PPO PLAN Out-of-Network Services
CALENDAR YEAR DEDUCTIBLE		
for these Procedure Types (combined)	Types 2 & 3	Types 2 & 3
INDIVIDUAL	$50	$50
FAMILY	$150	$150
PERCENT PAYABLE		
Type 1 - Diagnostic & Preventive Services	100%	100%
Type 2 - Basic Services	80%	80%
Type 3 - Major Services	50%	50%
Type 4 - Orthodontic Services for Dependent Children	50%	50%
Type 1, 2 and 3 Benefits Based On	Negotiated Fees	90th Percentile of Usual & Customary Allowance
CALENDAR YEAR MAXIMUM	$1,000	$1,000
for these Procedure Types (combined)	Types 1, 2 & 3	Types 1, 2 & 3
The *MaxRewards*SM Benefit is included. Please refer to the "Rollover of Calendar Year Maximum" page.		
LIFETIME MAXIMUM		
for Type 4 Procedures – Orthodontics for Dependent Children	$1,000	$1,000

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

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

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DEFINITIONS

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

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

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

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

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

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

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

COVERAGE MONTH means that period of time:

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

at the Group Policyholder's primary place of business.

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

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

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

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

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

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

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

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

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

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

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

EMPLOYEE means a Full-Time Employee of the Employer.

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

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

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

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

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

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

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

The leave period, may:

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

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

FULL-TIME EMPLOYEE means an employee of the Employer:

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

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

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

LATE ENTRANT means an eligible Employee who makes written application:
(1) more than 31 days after the Employee first becomes eligible for Employee Dental Coverage;
(2) after Employee Dental Coverage has been cancelled; or
(3) after Employee Dental Coverage has been terminated due to failure to pay premiums when due.

LATE ENTRANT also means an eligible Dependent for whom written application is made:
(1) more than 31 days after he or she first qualifies for Dependent Dental Coverage;
(2) after the Covered Employee has requested to terminate Dependent Dental Coverage; or
(3) after Dependent Dental Coverage has been terminated due to failure to pay premiums when due.

Exception for involuntary loss of coverage under another group dental plan. A person will not be considered a Late Entrant if, due to the existence of coverage under an employer's group dental plan, the Employee and/or any Dependents did not enroll within 31 days of becoming eligible for coverage under the Policy; and coverage under the other plan ends for one of the following reasons:
(1) termination of the other plan by the sponsoring employer;
(2) loss of the Employee's eligibility in the other plan due to his or her termination of employment or a change in his or her employment classification;
(3) loss of a spouse's eligibility under the other plan due to his or her termination of employment or a change in his or her employment classification; or
(4) loss of the Employee's or a Dependent's eligibility under the other plan due to a divorce or the death of the spouse.

This exception will not apply if:
(1) the loss of coverage under the other dental plan is voluntary (for example, voluntary termination of coverage based on premium contribution levels or the extent of benefits provided); or
(2) a person enrolls for coverage under the Policy more than 31 days after becoming eligible following the loss of coverage continued under COBRA.

In order to qualify for this exception, each person applying for coverage under the Employer's dental plan must:
(1) provide proof of coverage under the spouse's prior dental plan; and
(2) enroll for coverage and pay premiums for the Employer's plan within 31 days following loss of coverage under the other dental plan.

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

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

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

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

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

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

NON-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.

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

USUAL AND CUSTOMARY (U&C) means the maximum expense covered by the Policy. U&C allowances are based on dental charge information collected by nationally recognized industry databases. U&C allowances are reviewed and updated periodically. U&C allowances are determined by the zip code where the service is provided. The Group Policyholder elects the percentage level of the U&C allowance to be used as the basis for the maximum U&C allowance under the Policy.

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

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

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

ELIGIBILITY AND EFFECTIVE DATES FOR EMPLOYEE DENTAL COVERAGE

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

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

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

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

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

    and pay the first month's premium to the Company; or
(4) the first day of the Coverage Month coinciding with or next following the date the Company approves a Late Entrant's application.

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

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

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

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

TERMINATION OF EMPLOYEE DENTAL COVERAGE

TERMINATION. Your coverage will terminate on the earliest of:

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

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

DISABILITY. If you are disabled due to illness or injury; then coverage may be continued until the earliest of:

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

provided premium payments are made on your behalf.

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

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

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

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

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

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

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

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

subject to payment of premiums.

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

(1) your coverage ends due to termination of employment, reduction of hours, or layoff, and you return to qualifying full-time employment within 12 months of that event; or

(2) you go on an approved leave of absence, (other than for an approved Family or Medical Leave or for a Military Leave), and you return to qualifying full-time employment within six months of that event; or

(3) you return from an approved Family or Medical Leave within:
   (a) the period required by federal law; or
   (b) any longer period required by a similar state law; or

(4) your coverage ends due to military service of more than 30 days; and you apply for or return to qualifying full-time employment:
   (a) by the 14th day after completing military service of 31 to 180 days;
   (b) by the 90th day after completing military service of 181 days or longer; or
   (c) within 2 years if disabled upon completing such military service.

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

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

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 20 years of age;
(3) unmarried child, who is at least 20 years of age but less than 26 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 20 years or older, who is:
    (a) continuously unable to earn a living because of a physical or mental disability; and
    (b) chiefly dependent upon you for support and maintenance.

    The child must be covered by the Group Policyholder's dental plan on the day before coverage would otherwise end due to his or her age. Proof of the total disability must be sent to the Company:
    (a) within 31 days of the day coverage would otherwise end due to age; and
    (b) thereafter, when the Company requests (but not more than once every two years).

"Child" includes:

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

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

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

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

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

EFFECTIVE DATES FOR DEPENDENT DENTAL COVERAGE

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

(1) the first day of the Coverage Month coinciding with or next following the date you become eligible for Dependent Dental Coverage;

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

   and pay the first month's Dependent premium to the Company; or

(3) the first day of the Coverage Month coinciding with or next following the date the Company approves a Late Entrant application for each Dependent applying for Dependent Dental Coverage.

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

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

(1) you complete a written application; and

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

within 31 days of the date the Dependent is acquired.

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

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

TERMINATION OF DEPENDENT DENTAL COVERAGE

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

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

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

SURVIVING DEPENDENTS. If Employee Dental Coverage terminates due to your death, Dependent Dental Coverage may be continued:

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

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

(1) termination of employment, reduction of hours, or layoff, and you return to qualifying full-time employment within 12 months of that event;
(2) approved leave of absence, (other than for an approved Family or Medical Leave or for a Military Leave), and you return to qualifying full-time employment within six months of that event;
(3) return from an approved Family or Medical Leave within:
    (a) the period required by federal law; or
    (b) any longer period required by a similar state law; or
(4) military service of more than 30 days, and you apply for or return to qualifying full-time employment:
    (a) by the 14th day after completing military service of 31 to 180 days;
    (b) by the 90th day after completing military service of 181 days or longer; or
    (c) within 2 years if disabled upon completing such military service.

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

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

DENTAL EXPENSE BENEFITS

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

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

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

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

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

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

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

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

ALTERNATIVE PROCEDURES

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

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

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

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

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

DENTAL EXPENSE BENEFITS
ORTHODONTICS FOR CHILDREN

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

(1) begins Orthodontic Treatment while covered for Type 4 services (Orthodontics), under the Policy; and
(2) incurs Covered Expenses for Orthodontic Treatment after any Benefit Waiting Period or Late Entrant Limitation Period is satisfied; 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 Dependent Child's lifetime; but only for Covered Expenses Incurred while covered under the Policy.

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

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

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

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

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

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

LIMITATIONS AND EXCLUSIONS

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

(1) any procedure begun:
  (a) before you or your Dependent were covered under the Policy, subject to the Prior Plan Credit provision, if included in the Policy; or
  (b) after termination of your or your Dependent's coverage under the Policy.

(2) treatment or service which:
  (a) is not recommended by a Dentist or is not provided by or under the direct supervision of a Dentist;
  (b) is not a Necessary Dental Procedure, required for the care and treatment of a dental condition, as determined by the Company;
  (c) is not specifically listed as covered by the Policy;
  (d) does not meet generally accepted practices of dentistry; or
  (e) is provided by a physician or other health care provider, but is beyond the scope of his or her license.

(3) charges which exceed Covered Expenses, as defined in the Policy. Benefits will not be payable when:
  (a) total benefit payments would exceed the Annual or Lifetime Maximums payable under the Policy; or
  (b) services exceed the frequency limitations contained on the List of Covered Dental Procedures in the Policy.

(4) procedures which are subject to Benefit Waiting Periods or Late Entrant Limitation Periods, until those Benefit Waiting Periods or Late Entrant Limitation Periods have been satisfied.

(5) Orthodontic (Type 4) services:
  (a) which begin before your Dependent child becomes covered under the Policy for orthodontic services, subject to the Prior Plan Credit provision, if included in the Policy;
  (b) which begin during a Benefit Waiting Period or a Late Entrant Limitation Period, subject to the Prior Plan Credit provision, 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) except as specifically shown in the List of Covered Dental Procedures included in the Policy, any procedure associated with the placement, restoration, or removal of a dental implant, and any related expenses. Related expenses may include but are not limited to:
   (a) periodontal services which would not have been performed if the implant had not been planned and/or installed; and
   (b) any resulting increase in charges for services covered by the Policy that are related to the dental implant.

(9) any procedure related to a dental disease or Injury to natural teeth or bones of the jaw that is considered a covered service under any group medical plan.

(10) orthognathic recording, orthognathic surgery, osteoplasty, osteotomy, LeFort procedures, stomatoplasty, computed tomography imaging (CT scans), cone beam, or magnetic resonance imaging (MRIs).

(11) 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, if included in the Policy. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth.

(12) the adjustment, recementation, reline, rebase, replacement or repair of cast restorations, crowns and prostheses, within 6 months of the completion of the service.

(13) the replacement of any major restorative services—including, but not limited to, crowns, inlays, onlays, bridges, and dentures—within the time periods shown in the List of Covered Dental Procedures from the date of the last placement of these items. If a replacement is required because of an accidental dental Injury sustained while you or your Dependent is covered under the Policy, it will be a Covered Expense. If services related to the Injury are covered by your or your Dependent's group medical plan, those charges should be submitted to the medical plan first.

(14) specialized procedures, including:
   (a) precision or semi-precision attachments;
   (b) precious metals for removable appliances;
   (c) overlays and overdentures; or
   (d) personalization or characterization.

(15) duplicate prosthetics or appliances, or for initial placement or replacement of athletic mouth guards, night guards; and, except as specifically included in the List of Covered Dental Procedures contained in the Policy, bruxism appliances or any appliance to correct harmful habits; and for replacement of:
   (a) space maintainers; or
   (b) broken, misplaced, lost or stolen dental appliances.

(16) appliances, restorations or procedures, or their modifications, that:
- (a) alter vertical dimension;
- (b) restore or maintain occlusion or for occlusal adjustment or equilibration;
- (c) stabilize teeth;
- (d) replace tooth structure lost as a result of erosion, abfraction, abrasion or attrition;
- (e) surgically or non-surgically treat disturbances of the temporomandibular joint (TMJ), or other craniomandibular or temporomandibular disorders, except as required by law or as specifically shown in the List of Covered Dental Procedures; or
- (f) involve elimination of undercuts, box form, or concave irregularity caused in the preparation.

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

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

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

(20) except as specifically shown in the List of Covered Dental Procedures included in the Policy, charges which do not directly provide for the diagnosis or treatment of a dental Injury or condition, such as:
- (a) the completion of claim forms;
- (b) broken appointments;
- (c) interest or collection charges;
- (d) sales taxes, except where required by law, or other taxes or surcharges;
- (e) education, training and supplies used for dietary or nutritional counseling, personal oral hygiene or dental plaque control;
- (f) caries susceptibility tests, bacteriologic studies, oral cancer screenings, histopathologic exams or pulp vitality testing;
- (g) copying of x-rays or other dental records; or
- (h) duplication of services.

(21) itemized or separated charges for dental services, supplies or materials when those services, supplies and materials may be combined into a single, more comprehensive procedure payable under the Policy. This also includes itemized charges which are routinely included in the Dentist's charge for the primary service, such as:
- (a) sterilization or asepsis charges;
- (b) a charge for local anesthesia or analgesia, including nitrous oxide;
- (c) charges for pre- and post-operative care;
- (d) temporary or provisional dental services (for example, a temporary crown), which are considered to be part of the permanent service, except for interim dentures to replace teeth extracted while covered by the Policy.

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

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

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

(25) 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 THE POLICY'S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits ("COB") provision applies when a person has Dental Expense Benefits under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

DEFINITIONS

(1) A "**Plan**" is any of the following that provides benefits or services for dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(a) Plan includes: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); dental benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(b) Plan does not include: fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (a) or (b) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

(2) "**This Plan**" means, in a COB provision, the part of the Policy providing the dental care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the Policy providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

(3) The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has dental care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

(4) "**Allowable Expense**" is a dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

(a) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

(b) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(c) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

(d) The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions and preferred provider arrangements.

(5) "**Closed Panel Plan**" is a Plan that provides dental care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

(6) "**Custodial Parent**" is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

(1) The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

(2) (a) Except as provided in paragraph (b), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

(b) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the Group Policyholder. An example of this type of situation is insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

(3) A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

(4) Each Plan determines its order of benefits using the first of the following rules that apply:

(a) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

(b) Dependent child covered under more than one Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
   a. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
   b. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

   However, if one spouse's Plan has some other coordination rule (for example, a "gender rule" which says the father's Plan is always primary), the Company will follow the rules of that Plan.

2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   a. If a court decree states that one of the parents is responsible for the dependent child's dental care expenses or dental care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   b. If a court decree states that both parents are responsible for the dependent child's dental care expenses or dental care coverage, the provisions of Subparagraph 1. above shall determine the order of benefits;
   c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the dependent child, the provisions of Subparagraph 1. above shall determine the order of benefits; or
   d. If there is no court decree allocating responsibility for the dependent child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:
      i. The Plan covering the Custodial Parent;
      ii. The Plan covering the spouse of the Custodial Parent;
      iii. The Plan covering the non-Custodial Parent; and then
      iv. The Plan covering the spouse of the non-Custodial Parent.
3. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph 1. or 2. above shall determine the order of benefits as if those individuals were the parents of the child.

(c) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled (4)(a) can determine the order of benefits.

(d) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled (4)(a) can determine the order of benefits.

(e) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

(f) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

(1) When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other dental care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other dental care coverage.

(2) If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan , COB shall not apply between that Plan and other Closed Panel Plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Company any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION DISPUTES

If you believe that the Company has not paid a claim properly, you should first attempt to resolve the problem by contacting the Company. The website address and telephone number are found on your ID card. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at http://insurance.ohio.gov.

CLAIM PROCEDURES FOR DENTAL COVERAGE

NOTICE AND PROOF OF CLAIM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) immediately after the Company receives complete proof of claim and confirms liability; and
(2) in any event, within two months after the Company receives complete proof of claim.

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

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

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

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

This notice will be sent within 15 days after the Company resolves the claim; and, in any event, within two months after the Company receives complete proof of claim. It will be sent within 30 days after the Company receives the first proof of claim, if reasonably possible.

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

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

The notice will explain:

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

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

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

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

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

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

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

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

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

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

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

RIGHT OF RECOVERY. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:
(1) reduce future benefits until full reimbursement is made; and
(2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to:
(1) the Company's error in processing a claim;
(2) the claimant's receipt of benefits or services under another plan;
(3) fraud or any other reason.

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

COMPANY'S DISCRETIONARY AUTHORITY. Except for the functions that the Policy clearly reserves to the Group Policyholder or Employer, the Company has the authority to:
(1) manage the Policy and administer claims under it; and
(2) interpret the provisions and to resolve questions arising under the Policy.

The Company's authority includes (but is not limited to) the right to:
(1) establish and enforce procedures for administering the Policy and claims under it;
(2) determine your eligibility for insurance and entitlement to benefits;
(3) determine what information the Company reasonably requires to make such decisions; and
(4) resolve all matters when a claim review is requested.

Any decision the Company makes, in the exercise of its authority, shall be conclusive and binding; subject to the claimant's rights to:
(1) request a state insurance department review; or
(2) bring legal action.

NOTICE: A person is guilty of insurance fraud, if he or she submits an application or files a claim containing a false or deceptive statement:
(1) with intent to defraud an insurance company; or
(2) knowing that he or she is aiding a fraud against an insurance company.

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.

DENTAL COVERAGE CONTINUATION

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

RIGHT TO CONTINUE. Insurance may be continued in accord with the following provisions when:
(1) a Covered Person becomes ineligible for Policy coverage due to a Qualifying Event shown below; and
(2) the Policy remains in force.

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

"Qualifying Event," as it applies to your Covered Dependent, means one of the following events, if it would otherwise result in a Qualified COBRA Beneficiary's loss of Policy coverage:
(1) your termination of employment, retirement or hours reduction;
(2) your death, divorce or legal separation;
(3) your becoming entitled to Medicare benefits; or
(4) your child's ceasing to be an eligible Covered Dependent, under the terms of the Policy.

"Qualified Beneficiary" means you and your Covered Dependent who is entitled to continue insurance under the Policy, from the date of your first Qualifying Event. It also includes your natural child, legally adopted child or child placed for the purpose of adoption; when the new child:
(1) is acquired during your 18- or 29-month continuation period; and
(2) is enrolled for insurance in accord with the terms of the Policy.

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

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

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

(1) **Misconduct.** If your termination of employment is for gross misconduct, coverage may **not** be continued for you or your Covered Dependents.

(2) **Disability.** "Disability" or "Disabled" as used in this section, shall be as defined by Title II or XVI of the Social Security Act and determined by the Social Security Administration.

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

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

You must send the Company a copy of the Social Security Administration's notice of disability status:
(a) within 60 days after they find that you are disabled, and before the 18-month continuation period expires; and again
(b) within 30 days after they find that you are no longer disabled.

(3) **Subsequent Qualifying Event.** If your Dependent:
(a) is a Qualified Beneficiary; and
(b) has a subsequent Qualifying Event during the 18- or 29-month continuation period;
then coverage for that Covered Dependent may be continued for up to 36 months, from the date your employment ended.

Loss of Dependent Eligibility. If your Covered Dependent's eligibility ends, due to a Qualifying Event **other than** your termination of employment; then that Dependent's coverage may be continued for up to 36 months, from the date of the event. Such events may include:
(1) your death, divorce, legal separation, or Medicare entitlement; and
(2) your child's reaching the age limit, getting married or ceasing to be a full-time student.
One or more subsequent Qualifying Events may occur during your Covered Dependent's 36-month period of continued coverage; but coverage may not be continued beyond 36 months, from the date of the first Qualifying Event.

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

If your eligibility under the Policy continues beyond Medicare entitlement, but later ends due to a Qualifying Event; then your Covered Dependents may continue coverage for up to:
(1) 36 months from your Medicare entitlement date; or
(2) 18 months from the date of the first Qualifying Event (whichever is later).
Coverage may not be continued beyond 36 months, from the date of the first Qualifying Event.

NOTICE REQUIREMENTS. The Group Policyholder is required by law to notify the Company within 30 days after the following Qualifying Events:
(1) your termination of employment, hours reduction or retirement; and
(2) your death or becoming entitled to Medicare benefits.

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

DENTAL COVERAGE CONTINUATION
(Continued)

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

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

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

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

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

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

(1) **FMLA.** If you continue coverage during leave subject to the Family and Medical Leave Act (FMLA); then COBRA continuation may be elected from the day after the FMLA continuation period ends.

(2) **Other.** If you continue coverage under any other continuation privilege under the Policy; then that continuation period will run concurrently with any COBRA continuation period provided above.

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

ROLLOVER OF CALENDAR YEAR MAXIMUM

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

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

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

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

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

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

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

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

Calendar Year Maximum	Eligible Range	Rollover Amount without Preferred Provider Bonus	Rollover Amount with Preferred Provider	Maximum Rollover Account Balance
$1,000	$1 to $500	$250	$350	$1,000

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

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

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

PRIOR PLAN'S ROLLOVER ACCOUNT BALANCE. Rollover Account Balances accrued under your Employer's prior group dental plan may be applied toward a Covered Person's Rollover Account Balance under the Policy if the Covered Person:

(1) is covered under the Employer's prior group dental plan on the day before the Dental Expense Benefits under the Policy take effect;
(2) immediately becomes covered under the Policy on the day the Employer's Dental Expense Benefits under the Policy take effect; and
(3) provides written proof satisfactory to the Company of the Rollover Account Balance from the prior carrier.

Any Rollover Account Balance from a prior carrier is subject to the Policy's Maximum Rollover Account Balance.

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

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

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

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

- **FLUORIDE TREATMENTS**
  - two treatment per calendar year
  - for Dependent children through age 15
  - includes fluoride varnish for high-risk patients
  - does not include take-home or over-the-counter treatments

- **SPACE MAINTAINERS** (Passive Appliance)
  - one appliance per site while covered under this provision
  - for Dependent children through age 15
  - for the purpose of maintaining spaces created by the premature loss of primary teeth
  - includes all adjustments within six months after installation
  - does not include repairs or replacement costs

- **SEALANTS**
  - one treatment per tooth, no more than once in any 36-month period
  - for Dependent children through age 15
  - for the occlusal surface of unrestored and non-decayed first and second permanent molars only

- **EXAMINATIONS**
  - **Oral examinations**, problem-focused and/or emergency exams (other than routine periodic exams)
    - up to four per calendar year
    - Benefits are payable for an emergency examination or for emergency palliative treatment, but not both in the same visit

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

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

- **EMERGENCY TREATMENT**
  - **Emergency palliative treatment**
    - Palliative treatment is limited to:
      - opening and drainage of a tooth when no endodontics is to follow
      - opening and medicating
      - smoothing down a chipped tooth
      - dry socket treatment
      - pericoronitis treatment
      - treatment for apthous ulcers
  - Benefits are payable only if services are rendered in order to relieve dental pain or dental injury

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

- **ORAL SURGERY**
  - includes local anesthesia and routine post operative visits
  - **Biopsy and examination of oral tissue**
    - includes FDA-approved oral cancer screening system

- **APPLIANCE TO INHIBIT THUMB SUCKING AND OTHER HARMFUL HABITS**
  - one appliance while covered under the Policy
  - for Dependent children through age 15
  - includes all adjustments within six months after installation
  - does not include repairs or replacement costs

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

LIST OF COVERED DENTAL PROCEDURES
TYPE 2 PROCEDURES – BASIC SERVICES

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

- **INJECTION OF ANTIBIOTICS**
  - by the Dentist, in the Dentist's office

- **FILLINGS**
  - **Filling**
    - benefits for composite fillings of posterior teeth will be limited to the amount payable for an equivalent amalgam filling
    - multiple restorations on the same tooth will be treated as one restoration with multiple surfaces; and multiple restorations on one surface or adjacent surfaces will be treated as one restoration
    - replacement fillings for a tooth or tooth surface which was filled within the last 24 months are not covered
  - **Pin retention, in addition to restoration**

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

- **EXTRACTIONS AND ORAL SURGERY**
  - includes local anesthesia and routine post operative visits
  - extractions of asymptomatic teeth, except third molars (wisdom teeth), are not covered
  - extractions and surgical exposure of teeth, when related to orthodontic treatment, are not covered under this provision; however, if Covered Dental Procedures include orthodontic procedures, there may be coverage under that provision

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

- **Simple extraction**
- **Surgical removal of erupted tooth**
- **Removal of impacted tooth** (soft tissue, partially or completely bony)
- **Surgical exposure of impacted or unerupted tooth,** to aid eruption
- **Excision of hyperplastic tissue**
- **Excision of pericoronal gingiva**
- **Removal of exposed roots**
- **Surgical removal of residual tooth roots**
- **Excision of lesions, malignant or benign tumors**
- **Radical resection of bone for tumor with bone graft**
- **Incision and removal of foreign body from soft tissue**
- **Removal of foreign body from bone**
- **Maxillary sinusotomy for removal of tooth fragment or foreign body**
- **Suture of soft tissue wound**
  - excludes closure of surgical incisions
- **Incision and drainage of abscess**
- **Frenulectomy**
- **Sialolithotomy and Sialodochoplasty**
- **Dilation of salivary duct**
- **Sequestrectomy for osteomyelitis or bone abscess**
- **Closure of fistula,** salivary or oroantral
- **Reimplantation of tooth or tooth bud due to an accident**
- **Alveolectomy** (with or without extractions)
- **Vestibuloplasty**
- **Removal of exostosis of the maxilla or mandible**
  - includes removal of tori
- **Biopsy and examination of oral tissue**
  - includes brush biopsy

- **ADMINISTRATION OF ANESTHESIA**
  - **General anesthesia or I.V. sedation**
    - administered in the Dentist's office by the Dentist or other person licensed to administer anesthesia
    - payable in connection with:
      - a complex cutting procedure;
      - a documented health history that would require the administration of anesthesia;
      - a child through 6 years of age; or
      - a physically or developmentally disabled Covered Person
    - not covered when benefits for the accompanying surgical procedure are not payable
    - not covered when administered due to patient anxiety
    - anesthesia, when related to orthodontic treatment, is not covered under this provision; however, if Covered Dental Procedures include orthodontic procedures, there may be coverage under that provision

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

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

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

- **ENDODONTICS** (treatment of diseases of root canal, periapical tissue and pulp chamber)
  - **Pulp cap**, direct or indirect
    - not covered if done on the same day as the permanent restoration
  - **Pulpotomy**
    - primary teeth only
  - **Gross pulpal debridement**
  - **Root canal therapy**
    - permanent teeth only
    - includes necessary x-rays and cultures
    - retreatment of previous root canal therapy covered once per tooth per lifetime
  - **Root canal obstruction: non-surgical treatment**
  - **Incomplete endodontic therapy, inoperable or fractured tooth**
  - **Internal root repair of perforation defects**
  - **Apexification**
  - **Apicoectomy**
  - **Root amputation**
  - **Hemisection**

- **PERIODONTICS** (treatment of disease of the soft tissue or bone surrounding the tooth)

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

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

- **PERIODONTAL MAINTENANCE CLEANING**
  - up to two per calendar year
  - following active periodontal therapy
  - not covered if performed less than 3 months following periodontal surgery or scaling and root planing
- **NON-SURGICAL PERIODONTAL SERVICES**
  - not covered unless x-rays and pocket depth charting for each tooth confirm that the bone and attachment loss establish the Dental Necessity for treatment
  - benefit payment may be based on tooth, sextant or quadrant
  - **Full-Mouth Debridement**
    - one treatment per lifetime
  - **Scaling and root planing**, for pathological alveolar bone loss
    - one treatment in any 24-month period
    - not covered if performed less than 3 months following periodontal surgery
  - **Localized delivery of chemotherapeutic agent by means of a controlled release vehicle**
    - following active periodontal therapy which has failed to resolve the condition
    - one per tooth in any 36-month period
    - not payable within 60 days of periodontal therapy
- **PERIODONTAL SURGERY**
  - not covered unless x-rays and pocket depth charting for each tooth confirm that the bone and attachment loss establish the Dental Necessity for treatment
  - surgical treatment includes post operative visits
  - one operative session per quadrant in any 36-month period
  - benefits for multiple periodontal surgeries within the same quadrant on the same day will be paid based on the most comprehensive procedure provided that day
  - **Gingivectomy or gingivoplasty**
  - **Osseous surgery**
  - **Soft tissue graft**
  - **Bone replacement graft**
  - **Subepithial connective tissue graft**
  - **Guided tissue regeneration**
    - not covered under this provision if performed in a site where the tooth has been extracted
  - **Crown lengthening**

- **PROSTHODONTICS – Fixed or Removable**
  Services to replace teeth extracted or accidentally lost while covered under the Policy
  - includes adjustments, within six months of the placement date
  - benefits are not payable for temporary or provisional services
  - **Adjustments to dentures**, more than six months after installation
  - **Tissue conditioning**
    - one per arch per calendar year
  - **Reline of complete or partial denture**
    - one per calendar year, per denture
  - **Rebase of complete or partial denture**
    - once in any 5-year period, per denture

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

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

LIST OF COVERED DENTAL PROCEDURES
TYPE 3 PROCEDURES – MAJOR SERVICES

- **PROSTHODONTICS – Fixed or Removable**
  Services to replace teeth extracted or accidentally lost while covered under the Policy
  - includes adjustments, within six months of the placement date
  - benefits are not payable for temporary or provisional services
  - **Bridge abutments and pontics (fixed)**
    - replacement including a dental implant is limited to one time in any ten consecutive years from the placement date of the same or any other type of prosthetic at the same site, unless replacement is required due to an accidental Injury
  - **Dentures, complete** (upper or lower) **or partial** (upper or lower) **or unilateral partial (removable)**
    - fees for partial dentures include all conventional clasps, rests and teeth
    - includes addition of teeth or clasp(s) to an existing partial denture to replace natural teeth extracted or accidentally lost while covered under the Policy
    - replacement including a dental implant is limited to once in any ten consecutive years, per denture, from the placement date of the same or any other type of prosthetic at the same site, unless replacement is required due to an accidental Injury, provided the existing denture is not serviceable
  - **Dental implants**
    - not covered for claimants prior to age 16
    - implants are limited to one per tooth in any ten consecutive years; or sooner, if a replacement is required because of an accidental dental injury sustained while the Covered Person is covered under the Policy
  - **Surgical placement of implant body**
  - **Implant prosthetics**
    - implant-supported crown
    - abutment-supported crown
    - implant abutment (includes placement)
    - implant-supported retainer
    - abutment-supported retainer
  - **Other implant procedures**
    - implant maintenance procedures
    - repair implant abutment
    - repair implant-supported prosthesis
    - removal of implant body
  - **Bone replacement graft,** at the site of an extracted tooth
    - one per site while covered under the Policy
  - **Guided tissue regeneration,** at the site of an extracted tooth
    - one per site while covered under the Policy

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

- **MAJOR RESTORATIONS**
  - inlays, onlays, veneers, and crowns are covered only when needed due to substantial loss of tooth structure caused by decay or accidental Injury to teeth and when the tooth cannot be restored by other more conservative methods
  - benefits are not payable for the placement of an inlay, onlay, veneer, or crown within ten years since the placement date of an inlay, onlay, veneer, or crown on the same tooth, unless replacement is required due to an accidental Injury
  - benefits are not payable for temporary or provisional services
  - temporary services in place for one year or more are considered to be permanent services and are subject to the Policy's frequency limitations
  - not covered for claimants prior to age 16
  - **Inlays**
  - **Onlays**
  - **Crowns and posts**
  - **Crown build-up**, in conjunction with a payable crown
  - **Cast post and core**, in conjunction with a payable crown
  - **Cast post**, as part of a payable crown
  - **Veneers**

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

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

- **ORTHODONTICS**
  Active and passive services related to the guidance and alignment of teeth
  - **Diagnostic services**
    - **Examinations**
    - **X-rays**
    - **Diagnostic casts or study models**
  - **Treatment plan**
  - **Orthodontic extractions**
    - includes anesthesia, if Necessary
  - **Transseptal Fibrotomy**
  - **Orthodontic appliances**

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

Notice Concerning Coverage

Limitations and Exclusions under the Ohio Life And Health Insurance Guaranty Association Act

Residents of Ohio who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Ohio Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is **NOT** provided for your policy or any portion of it that is not guaranteed by the insurer, or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.**

Ohio Life and Health Insurance Guaranty Association
1840 Mackenzie Drive
Columbus, OH 43220

Ohio Department of Insurance
50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215

The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract, if they are insured under a group insurance contract, issued by a member insurer, or if they are the payee or beneficiary of a structured settlement annuity contract. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a medical, health or dental care corporation, an HMO; a fraternal benefit society; a mutual protective association or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000, except as specified below, no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. The association will not pay more than $100,000 in cash surrender values, $500,000 in major medical insurance benefits, $300,000 in disability or long-term care insurance benefits, $100,000 in other health insurance benefits, $250,000 in present value of annuities, or $300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages, the association will pay a maximum of $300,000, except for coverage involving major medical insurance benefits, for which the maximum of all coverages is $500,000.

Note to benefit plan trustees or other holders of unallocated annuities (G/Cs, DACs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under §§401, 403(b), or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual, except as noted above. For covered unallocated annuities that fund other plans, a special limit of $1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

For more information about the Ohio Life & Health Insurance Guaranty Association, visit our website at: www.olhiga.org.

SUMMARY PLAN DESCRIPTION

The following information together with your group insurance certificate issued to you by The Lincoln National Life Insurance Company of Fort Wayne, Indiana, is the Summary Plan Description required by the Employee Retirement Income Security Act of 1974 to be distributed to participants in the Plan. This Summary Plan Description is only intended to provide an outline of the Plan's benefits. The Plan Document will govern if there is any discrepancy between the information contained in this Description and the Plan.

The name of the Plan is: Group Dental Insurance for Employees of United Cerebral Palsy Association of Greater Cleveland, Inc..

The name, address and ZIP code of the Sponsor of the Plan is: United Cerebral Palsy Association of Greater Cleveland, Inc., 10011 Euclid Ave., Cleveland, Ohio, 44106.

Employer Identification Number (EIN): 34-0753561 IRS Plan Number: 501

The name, business address, ZIP code and business telephone number of the Plan Administrator is: United Cerebral Palsy Association of Greater Cleveland, Inc., 10011 Euclid Ave., Cleveland, Ohio, 44106, (216) 453-4954.

The Plan Administrator is responsible for the administration of the Plan and is the designated agent for the service of legal process for the Plan. Functions performed by the Plan Administrator include: the receipt and deposit of contributions, maintenance of records of Plan participants, authorization and payment of Plan administrative expenses, selection of the insurance consultant, selection of the insurance carrier and assisting The Lincoln National Life Insurance Company. The Lincoln National Life Insurance Company has the sole discretionary authority to determine eligibility and to administer claims in accord with its interpretation of policy provisions, on the Plan Administrator's behalf.

Type of Administration. The Plan is administered directly by the Plan Administrator with benefits provided in accordance with provisions of the group insurance policy issued by The Lincoln National Life Insurance Company whose Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska.

Type of Plan. The benefits provided under the Plan are: Group Dental Insurance benefits.

Type of Funding Arrangement: The Lincoln National Life Insurance Company.

All employees are given a Certificate of Group Insurance which contains a detailed description of the Benefits, COBRA continuation rights, Exclusions and Limitations, Preventive Services, Predetermination Procedures and Prior Carrier Credit provisions. The Certificate also contains the Schedule of Benefits which includes information on the Eligibility and Benefit Waiting Periods, Deductibles, Percentages Payable, and Annual and Lifetime Maximums (if any). If your Booklet, Certificate or Schedule of Benefits has been misplaced, you may obtain another copy from the Plan Administrator at no charge.

Eligibility. Full-time employees working at least 30 hours per week.

Employees become eligible on the first of the month coinciding with or next following completion of 60 days of active full-time employment.

Contributions. You are required to make contributions for Employee Dental Coverage. You are required to make contributions for Dependent Dental Coverage.

The Plan's year ends on: April 30th of each year.

The name and section of relevant Collective Bargaining Agreements: None

The name, title and address of each Plan Trustee: None

Loss of Benefits. The Plan Administrator may terminate the policy, or, subject to The Lincoln National Life Insurance Company's approval, may modify, amend or change the provisions, terms and conditions of the policy. Coverage will also terminate if the premiums are not paid when due. No consent of any Insured Person or any other person referred to in the policy will be required to terminate, modify, amend or change the policy. See your Plan Administrator to determine what, if any, arrangements may be made to continue your coverage beyond the date you cease active work.

Claims Procedures. You may obtain claim forms and instructions for filing claims from the Plan Administrator or from the Group Insurance Service Office of The Lincoln National Life Insurance Company. To expedite the processing of your claim, instructions on the claim form should be followed carefully; be sure all questions are answered fully. In accordance with ERISA, The Lincoln National Life Insurance Company will send you a written notice of its claim decision within:

- 30 days after receiving the first proof of a claim (45 days under special circumstances).

If a claim is partially or wholly denied, this written notice will explain the reason(s) for denial, how a review of the decision may be requested, and whether more information is needed to support the claim. You may request a review of the claim by making a written request to The Lincoln National Life Insurance Company within:

- 180 days after receiving a denial notice of a claim.

This written request for review should state the reasons why you feel the claim should not have been denied and should include any additional documentation to support your claim. You may also submit for consideration additional questions or comments you feel are appropriate, and you may review certain non-privileged information relating to the request for review. The Lincoln National Life Insurance Company will make a full and fair review of the claim and provide a final written decision to you within:

- 30 days after receiving the request for review of a claim.

If more information is needed to resolve a claim, the information must be supplied within 45 days after requested. Any resulting delay will not count toward the above time limits for claims or appeals processing. Please refer to your certificate of insurance for more information about how to file a claim, how to appeal a denied claim, and for details regarding the claims procedures.

Statement of ERISA Rights

The following statement of ERISA rights is required by federal law and regulation. As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if any, and updated summary plan description. The administrator may make a reasonable charge for copies.

Receive a summary of the plan's annual financial report if the plan covers 100 or more participants. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Lincoln Financial Group®

Lincoln Financial Group® Privacy Practices Notice

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

Information We May Collect And Use

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

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

How We Use Your Personal Information

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

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

Security of Information

We have an important responsibility to keep your information safe. We use safeguards to protect your information from unauthorized disclosure. Our employees are authorized to access your information only when they need it to provide you with products, services, or to maintain your accounts. Employees who have access to your personal information are required to keep it confidential. Employees are required to complete privacy training annually.

Your Rights Regarding Your Personal Information

Access: We want to make sure we have accurate information about you. Upon written request we will tell you, within 30 business days, what personal information we have about you. You may see a copy of your personal information in person or receive a copy by mail, whichever you prefer. We will share with you who provided the information. In some cases we may provide your medical information to your personal physician. We will not provide you with information we have collected in connection with, or in anticipation of, a claim or legal proceeding. If you request a copy of the information, we may charge you a fee for copying and mailing costs. In very limited circumstances, your request may be denied. You may then request that the denial be reviewed.

Accuracy of Information: If you feel the personal information we have about you is inaccurate or incomplete, you may ask us to amend the information. Your request must be in writing and must include the reason you are requesting the change. We will respond within 30 business days. If we make changes to your records as a result of your request, we will notify you in writing and we will send the updated information, at your request, to any person who may have received the information within the prior two years. We will also send the updated information to any insurance support organization that gave us the information, and any service provider that received the information within the prior 7 years. If your requested change is denied, we will provide you with reasons for the denial. You may write to request the denial be reviewed. A copy of your request will be kept on file with your personal information so anyone reviewing your information in the future will be aware of your request.

Accounting of Disclosures: If applicable, you may request an accounting of disclosures made of your medical information, except for disclosures:

- For purposes of payment activities or company operations;
- To the individual who is the subject of the personal information or to that individual's personal representative;
- To persons involved in your health care;
- For notification for disaster relief purposes;
- For national security or intelligence purposes;
- To law enforcement officials or correctional institutions;
- Included in a limited data set; or
- For which an authorization is required.

You may request an accounting of disclosures for a time period of less than six years from the date of your request.

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

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

If you have questions about your personal information, please provide your full name, address and telephone number and either email your question to our Data Subject Access Request Team at DSAR@lfg.com or mail to:

Lincoln Financial Group
ATTN: Corporate Privacy Office, 7C-01
1300 S. Clinton St.
Fort Wayne, IN 46802

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

First Penn-Pacific Life Insurance Company
Lincoln Financial Distributors, Inc.
Lincoln Financial Group Trust Company
Lincoln Investment Advisors Corporation
Lincoln Life & Annuity Company of New York
Lincoln Life Assurance Company of Boston
Lincoln Retirement Services Company, LLC
Lincoln Variable Insurance Products Trust
The Lincoln National Life Insurance Company

Lincoln Financial Group® Privacy Notice for Protected Health Information

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

You have received this Notice because you have applied for, or currently have, insurance coverage or an annuity ("Coverage"), that contains benefit provisions subject to the federal privacy regulations that were issued as a result of the Health Insurance Portability and Accountability Act, as amended ("HIPAA"). This is Coverage that has been, or will be issued with one of the Lincoln Financial Group insurance companies* ("Company"). This Notice sometimes refers to the Company by using the terms "us," "we," or "our." We value our relationship with you and are committed to protecting the confidentiality and security of information we collect about you, especially health information.

We collect, use and disclose information about you to evaluate and process any requests for Coverage and claims for benefits you may make regarding your Coverage. This Notice describes how we protect the individually identifiable health information we have about you which relates to your Coverage ("Protected Health Information"), and how we may use and disclose this information. Protected Health Information includes individually identifiable information that relates to your past, present or future health, treatment or payment for health care services. The Company will never share your information for marketing purposes or allow for the sale of your information, unless you give us your written permission. This Notice also describes your rights with respect to the Protected Health Information and how you can exercise those rights.

We are required to provide you with this Notice in accordance with federal health privacy regulations that were issued as a result of HIPAA. We are required by law to maintain the privacy of your Protected Health Information; to provide you this Notice of our legal duties and privacy practices with respect to your Protected Health Information; and to follow the terms of this Notice.

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

Uses and Disclosures of your Protected Health Information

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

Authorization: Except as described below, we will not use or disclose your Protected Health Information for any reason unless we have a signed authorization from you or your legal representative to use or disclose your Protected Health Information. You or your legal representative has the right to revoke an authorization in writing, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition of obtaining your Coverage.

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

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

Health Care Operations: We may use and disclose your Protected Health Information for our insurance operations. Our insurance operations may include underwriting, premium rating, and other activities related to the issuance, renewal or replacement of Coverage, or for reinsurance purposes. For example, when you apply for insurance we may collect medical information from your doctor (health care provider) or a medical facility that provided you health care services to determine if you qualify for insurance. We may also use and disclose Protected Health Information to conduct or arrange for medical review, legal services, contract for reinsurance, business planning and development regarding the management and operation of our Coverage processes, or auditing, including fraud and abuse detection and compliance programs. Protected Health Information may also be disclosed for customer service, servicing our current and future customer relationships as permitted by law, resolution of internal grievances and as part of a potential sale, transfer, merger, or consolidation in order to make an informed business decision regarding any such prospective transaction. For group plans, Protected Health Information may be disclosed to your Plan Sponsor for purposes of administering your Plan or any other health plan maintained by your employer to facilitate claims payments under the plan. If we use or disclose Protected Health Information for underwriting purposes, the Protected Health Information used or disclosed for that purpose will not include information that constitutes genetic information.

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

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

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

- To state or local health authorities, as required by law, of particular communicable diseases, injury, birth, death, and for other required public health investigations;
- To a governmental agency or regulator with health care oversight responsibilities;
- To a coroner, medical examiner or funeral director to assist in identifying a deceased individual or to determine the cause of death;
- To public health or other appropriate authorities, as required by law, when there is reason to suspect abuse, neglect, or domestic violence;
- To the Food and Drug Administration (FDA) for purposes related to quality, safety or effectiveness of FDA-regulated products or activities;
- If required by law to do so by a court or administrative tribunal ordered subpoena or discovery request, or for law enforcement purposes as permitted by law. We will make efforts to notify you of such requests or to obtain an order protecting the Protected Health Information requested. We may disclose Protected Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination;
- For certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy;
- If you are a member of the military as required by armed forces services;
- To federal officials for intelligence, counterintelligence, and other national security activities authorized by law;
- To worker's compensation agencies if necessary for your worker's compensation benefit determination;
- To avert a serious threat to someone's health or safety, including the disclosure of Protected Health Information to government or privacy disaster relief or assistance agencies to allow such entities to carry out their responsibilities to specific disaster situations;
- To organizations that manage organ procurement or organ, eye or tissue transplant or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplant. Releasing Protected Health Information to a correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Required Disclosures

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

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

Disclosures to You. When you request, we are required to disclose to you the portion of your Protected Health Information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested by you, to provide you with an accounting of most disclosures of your Protected Health Information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the Protected Health Information was not disclosed pursuant to your individual authorization. Please refer to the further description of your right to receive an accounting below.

Your Rights Regarding Your Protected Health Information

You have the following rights as a consumer under HIPAA concerning the Protected Health Information we have about you in our records. Any request to exercise your rights as described below should be made in writing and sent to **Lincoln Financial Group, Attn: Corporate Privacy Office - 7C-01, 1300 S Clinton Street, Fort Wayne IN 46802.** Also, should you wish to terminate a request for a restriction that has been accommodated, such termination request must also be in writing and sent to the same address listed above. Your request to exercise the rights described below should include the following information: your full name, address, and policy number. Generally, we will respond to these requests within 30 days of receipt.

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

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

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

Right to Amend Your Protected Health Information: You have the right to request that we amend your Protected Health Information in our records if you believe it is inaccurate or incomplete. Your request must be in writing and sent to the address provided above. Your request must provide your reason(s) for seeking the amendment or correction. If an amendment or correction request is accepted, we will amend or correct all appropriate records as well as notify others to whom we have disclosed the erroneous Protected Health Information. We may deny your request if you ask us to amend Protected Health Information that is accurate and complete; was not created by us, unless the creator of the Protected Health Information is no longer available to make the amendment; is not part of the Protected Health Information kept by or for us; or is not part of the Protected Health Information which you would be permitted to inspect and copy. If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of your Protected Health Information will include your statement.

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

- For treatment;
- For payment or health care operations;
- To law enforcement, for purposes of national security;
- To department of corrections personnel;
- Pursuant to your authorization;
- Incidental to a permitted disclosure;
- or directly to you.

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

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

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

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

For Further Information: For further information regarding this Notice or the Company's privacy practices, please contact **Lincoln Financial Group, Attn: Corporate Privacy Office - 7C-01, 1300 S Clinton Street, Fort Wayne IN 46802, or call 1-877-275-5462.**

Effective Date: This Notice is effective February 22, 2018.

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

First Penn-Pacific Life Insurance Company

Lincoln Life & Annuity Company of New York

The Lincoln National Life Insurance Company