TAMMY SCARFE
LONG FALLS PAPERBOARD
161 WELLINGTON RD
BRATTLEBORO VT 05301

1163412

10/01/2022

GROUP POLICY FOR:

LONG FALLS PAPERBOARD LLC

ALL MEMBERS
Group Dental Preferred Provider Organization (PPO) Insurance

Print Date: 10/17/2022

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PRINCIPAL LIFE INSURANCE COMPANY
(called The Principal in this Group Policy)
Des Moines, Iowa 50392-0002

This group insurance policy is issued to:

LONG FALLS PAPERBOARD LLC
(called the Policyholder in this Group Policy)

The Date of Issue is October 1, 2022.

In return for the Policyholder's application and payment of all premiums when due, The Principal agrees to provide:

MEMBER AND DEPENDENT

GROUP DENTAL EXPENSE INSURANCE

PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

subject to the terms and conditions described in this Group Policy.

Senior Vice President,
General Counsel and Secretary

Chairman, President and
Chief Executive Officer

GROUP POLICY NO. GDE 1163412
NONPARTICIPATING
CONTRACT STATE OF ISSUE: VERMONT

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PART I - DEFINITIONS

When used in this Group Policy, the terms listed below will mean:

Accidental Injury

An injury to the natural teeth that results solely from accidental means (excluding any injury that occurs from chewing).

Active Work; Actively At Work

The active performance of all of a Member's normal job duties at the Policyholder's usual place or places of business.

Calendar Year

January 1 through December 31 of each year.

Covered Charges

A Treatment or Service is considered to be a Covered Charge if the Treatment or Service is prescribed by a Dentist and is determined by The Principal to be:

a. necessary and appropriate;

b. Generally Accepted.

Date of Issue

The date this Group Policy is placed in force: October 1, 2022.

Deductible; Deductible Amount

A specified dollar amount of Covered Charges that must be incurred by the Member or Dependent before benefits will be payable under this Group Policy for all or part of the remaining Covered Charges during the Calendar Year.

Dental Charges Database (DCD)

A commercially available dental charge information database selected by The Principal that provides historical information about the charges of dental care providers by procedure code and geographic categories, all as determined and adjusted by the database supplier. The Dental Charges Database will be updated by The Principal as information becomes available from the database supplier, up to twice each year. The Principal may also modify the database at its discretion to reflect its own experience. The Principal has discretion to substitute or replace the selected database with a database or databases of comparable purpose, including a database using information of The Principal only, as determined and adjusted by The Principal, with or without notice. When there is minimal data available, as determined by The Principal, from the DCD for a Treatment or Service, The Principal will determine the Prevailing Charge by calculating the unit cost for the applicable Treatment or Service category using the DCD and multiplying by the relative value of the Treatment or Service based upon a relative value scale selected by The Principal. When considering a complex Treatment or Service or a Treatment or Service that is a new procedure or otherwise does not have a relative value that is applicable, The Principal will assign one. The determination of the Prevailing Charge does not take into account the Non-Preferred Provider's training, experience or category of licensure.

Dental Hygienist

A person who works under the supervision of a Dentist and is licensed to practice dental hygiene.

Dental Treatment Plan

A Dentist's report of proposed dental treatment which:

a. is in Writing; and

b. lists the procedures required for the Period of Dental Treatment; and

c. shows the charges for each procedure; and

d. is accompanied by any diagnostic materials The Principal might request.

Dentist

a. A person licensed to practice dentistry; and

b. a licensed Physician who provides dental Treatment or Service.

Dependent

a. A Member's spouse, if that spouse:

(1) is not in the Armed Forces of any country; and
(2) is not insured under this Group Policy as a Member.

b. A Member's Dependent Child (or Children) as defined below.

Dependent Child; Dependent Children

a. A Member's natural child, if that child:

(1) is not insured under this Group Policy as a Member; and
(2) is less than 26 years of age.

b. A Member's stepchild, if that child:

(1) meets the requirements above; and
(2) receives principal support from the Member.

c. A Member's foster child, if that child:

(1) meets the requirements above; and
(2) lives with the Member; and
(3) receives principal support from the Member; and
(4) is under legal guardianship of the Member or the Member's spouse; and
(5) is approved in Writing by The Principal as a Dependent Child.

d. A Member's adopted child, if that child meets the requirements above and the Member:

(1) is a party in a lawsuit in which the Member is seeking the adoption of the child; or
(2) has custody of the child under a court order that grants custody of the child to the Member.

An adopted child will be considered a Dependent Child on the earlier of: the date the petition for adoption is filed; or the date of entry of an order granting the adoptive parent custody of the child for the purpose of adoption.

Dependent Child will include any child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to this Group Policy, provided the child meets this Group Policy's definition of a Dependent Child.

Developmental Disability

A Dependent Child's substantial handicap, as determined by The Principal, which:

a. results from mental disability, cerebral palsy, epilepsy, or other neurological disorder; and

b. is diagnosed by a Physician as a permanent or long term continuing condition.

Emergency Treatment

Any Treatment or Service, as determined by The Principal, which is rendered as the direct result of an unforeseen occurrence or combination of circumstances that requires immediate, urgent action or remedy.

Experimental or Investigational Measures

Any Treatment or Service, regardless of any claimed therapeutic value, not Generally Accepted by a specialist in that particular field of dentistry, as determined by The Principal.

Full-Time Employee

Any person, residing in the United States, who is a U.S. citizen or is legally working in the United States, who is regularly scheduled to work for the Policyholder for at least 24 hours a week. The employee must be compensated by the Policyholder and either the employer or employee must be able to show taxable income on federal or state tax forms. Work must be at the Policyholder's usual place or places of business or at another place in which an employee performs his or her regular duties. A person is considered to be residing in the United States if his or her main home or permanent address is in the United States or if the person is in the United States for six months or more during any 12-month period.

An owner, proprietor, or partner of the Policyholder's business will be deemed to be an eligible employee for purposes of this Group Policy, provided he or she is regularly scheduled to work for the Policyholder for at least 24 hours a week and otherwise meets the definition of Full-Time Employee.

Functioning Natural Tooth

A Natural Tooth which is performing its normal role in the chewing process in the insured person's upper or lower arch and which is opposed in the person's other arch by another Natural Tooth or prosthetic (i.e. artificial) replacement.

Generally Accepted

Treatment or Service which is the subject of claim that:

a. has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed dental and scientific literature; and

b. is in general use in the relevant dental community; and

c. is not under scientific testing or research.

Group Policy

The policy of group insurance issued to the Policyholder by The Principal which describes benefits and provisions for insured Members and Dependents.

Harmful Habit Appliances

Appliances, either fixed or removable, used to train or remind a patient to avoid thumb sucking or tongue thrusting (does not include treatment for bruxism - clenching or grinding of the teeth).

Immediate Family

An insured person's spouse, natural or adoptive parent, natural or adoptive child, sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild or spouse of grandparent or grandchild.

Insurance Month

Calendar month.

Lapse in Coverage

Any break in coverage during which a person is not covered under another group dental expense coverage, including but not limited to any Policyholder benefit waiting period. Continuation provided under COBRA or any state required continuation will not be considered a break in coverage.

Member

Any PERSON who is a Full-Time Employee or Part-Time Employee of the Policyholder.

Natural Tooth

Any tooth or part of a tooth that is organic and formed by the natural development of the body (i.e. not manufactured).

Non-Preferred Provider/Non-PPO Provider

A Dentist not contracted with the Dental Preferred Provider Organization (PPO) network identified by The Principal to this Group Policy.

Orthodontic Treatment or Service

Any Treatment or Service for:

a. straightening of teeth, formal, full-banded retention and treatment, including x-rays and other diagnostic procedures; and

b. removable or fixed appliances for tooth or bony structure guidance or retention.

Part-Time Employee

Any person, residing in the United States, who is a U.S. citizen or is legally working in the United States, who is regularly scheduled to work for the Policyholder for at least 17 1/2 hours a week. The employee must be compensated by the Policyholder and either the employer or employee must be able to show taxable income on federal or state tax forms. Work must be at the Policyholder's usual place or places of business or at another place to which an employee performs his or her regular duties. A person is considered to be residing in the United States if his or her main home or permanent address is in the United States or if the person is in the United States for six months or more during any 12-month period.

An owner, proprietor, or partner of the Policyholder's business will be deemed to be an eligible employee for purposes of this Group Policy, provided he or she is regularly scheduled to work for the Policyholder for at least 17 1/2 hours a week and otherwise meets the definition of Part-Time Employee.

Period of Dental Treatment

All sessions of dental care that result from the same initial diagnosis and any related complications.

Physical or Mental Incapacity

A Dependent Child's substantial physical or mental incapacity, as determined by The Principal, which:

a. results from injury, accident, congenital defect, or sickness; and

b. is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.

Physician

A licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.).

Placement for Adoption; Placement

The assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

Policy Anniversary

January 1, 2024, and the same day of each following year.

Policyholder

The entity to whom this Group Policy is issued (see Title Page).

Preferred Provider/PPO Provider

A Dentist contracted with a Dental Preferred Provider Organization (PPO) network identified by The Principal to this Group Policy.

The Policyholder participating in a PPO network does not mean that the insured person's choice of provider will be restricted. The insured person may seek needed dental care from any Dentist of his or her choice. However, in order to avoid higher charges and reduced benefit payment, the insured persons are urged to obtain such care from Preferred Providers whenever possible.

The Principal has the right to terminate the Preferred Provider Organization (PPO) portion of this Group Policy if The Principal or the Preferred Provider Organization (PPO) terminates the arrangement.

The Principal also has the right to identify different preferred provider organizations from time to time, and to terminate the designation of any Preferred Provider at any time.

Prevailing Charges

a. For dental care received from Preferred Providers, the negotiated fee between the Preferred Provider and the PPO.

b. For dental care received from Non-Preferred Providers, the amount that most dental care providers charge within a geographic cost area for Treatment or Service.

For purposes of the coverage provided under this Group Policy, an actual charge for a Treatment or Service will be in excess of Prevailing Charges only if, as determined by The Principal, 90% or more of all other charges reported to The Principal for the same (or a similar) Treatment or Service provided within the same (or a comparable) cost area are lower in amount than the actual charge.

For purposes of Treatment or Service provided outside the United States, the Prevailing Charge will be calculated based on the Policyholder's United States address.

Second Opinion

An opportunity to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed Treatment or Service to assess the clinical necessity and appropriateness of the proposed service.

Second Opinion Consultation Charges

Covered Charges for:

a. consultation with a Second Opinion Physician to obtain a Second Opinion prior to a Treatment or Service for which a Second Opinion is recommended; and

b. necessary diagnostic, x-ray or laboratory examinations performed in connection with such consultation.

Second Opinion Physician

A Physician or Dentist who is:

a. an appropriate specialist for the particular Treatment or Service recommended; and

b. not a partner or associate of the Physician or Dentist who recommended or will perform the Treatment or Service.

Signed or Signature

Any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by The Principal.

Treatment or Service

When used in this Group Policy, the term "Treatment or Service" will be considered to mean "treatment, service, substance, material, or device".

Written or Writing

A record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

PART II - POLICY ADMINISTRATION

Section A - Contract

Article 1 - Entire Contract

This Group Policy, the current Certificate, and the attached Policyholder application, make up the entire contract. The Principal is obligated only as provided in this Group Policy and is not bound by any trust or plan to which it is not a signatory party.

Article 2 - Policy Changes

Insurance under this Group Policy runs annually to the Policy Anniversary, unless sooner terminated. No agent, employee, or person other than an officer of The Principal has authority to change this Group Policy, and, to be effective, all such changes must be in Writing and Signed by an officer of The Principal.

The Principal reserves the right to change this Group Policy as follows:

a. Any or all provisions of this Group Policy may be amended or changed at any time, including retroactive changes, to the extent necessary to meet the requirements of any law or any regulation issued by any governmental agency to which this Group Policy is subject.

b. Any or all provisions of this Group Policy may be amended or changed at any time when The Principal determines that such amendment is required for consistent application of policy provisions.

c. By Written agreement between The Principal and the Policyholder, this Group Policy may be amended or changed at any time as to any of its provisions.

Any change to this Group Policy, including, but not limited to, those in regard to coverage, benefits, and participation privileges, may be made without the consent of any Member or Dependent.

Payment of premium beyond the effective date of the change constitutes the Policyholder's consent to the change.

Article 3 - Policyholder Eligibility Requirements

To be an eligible group and to remain an eligible group, the Policyholder must:

a. be actively engaged in business for profit within the meaning of the Internal Revenue Code, or be established as a legitimate nonprofit corporation within the meaning of the Internal Revenue Code; and

b. make at least the level of premium contributions required for insurance on its eligible Members. The Policyholder must contribute at least 50% of the required premium for all Members (including disabled Members, if any); and

c. if the Member is to contribute part of the premium, maintain the following participation with respect to eligible employees and Dependents:

(1) Employees:

- at least 50% of all eligible employees must enroll;

(2) Dependents:

- maintain a Dependent participation of at least 50% of eligible Dependents; and

d. if the Member is to contribute no part of the premium, 100% of eligible employees and Dependents must enroll; and

e. insure five or more Members for Member Dental Expense Insurance to elect orthodontia.

For the purpose of determining the applicable participation shown in c. above, Members and Dependents who have existing coverage under other group insurance, Medicaid, TRICARE, or COBRA continuation will be removed from the calculation.

If a Policyholder had prior coverage with The Principal which coverage terminated due to nonpayment of premium, fraud or misrepresentation or material fact or failure to comply with minimum participation or employer contribution requirements, The Principal will not accept application from that Policyholder within 12 months after the date of such termination.

Article 4 - Policy Incontestability

In the absence of fraud, after this Group Policy has been in force three years, The Principal may not contest its validity except for nonpayment of premium.

Article 5 - Individual Incontestability and Eligibility

All statements made by any individual insured under this Group Policy will be representations and not warranties. These statements may not be used to contest an insured person's insurance unless:

a. the insured person's insurance has been in force for less than three years during the insured's lifetime; and

b. the statement is in Written form Signed by the insured person; and

c. a copy of the form which contains the statement is given to the insured or the insured's beneficiary at the time insurance is contested.

However, these provisions will not preclude the assertion at any time of defenses based upon the person's ineligibility for insurance under this Group Policy or upon the provisions of this Group Policy. In addition, if an individual's age is misstated, The Principal may at any time adjust premium and benefits to reflect the correct age.

Article 6 - Information to be Furnished

The Policyholder must, upon request, give The Principal all information needed to administer this Group Policy. If a clerical error is found in this information, The Principal may at any time adjust premium to reflect the facts. An error will not invalidate insurance that would otherwise be in force. Neither will an error continue insurance that would otherwise be terminated.

The Principal may inspect, at any reasonable time, all Policyholder records which relate to this Group Policy.

Article 7 - Certificates

The Principal will give the Policyholder Certificates for delivery to insured Members. The delivery of such Certificates will be in either paper or electronic format. The Certificates will be evidence of insurance and will describe the basic features of the benefit plan. They will not be considered a part of this Group Policy.

Article 8 - Workers' Compensation Not Affected

This Group Policy is not in place of and does not affect nor fulfill the requirements for Workers' Compensation Insurance.

Article 9 - Dependent Rights

A Dependent will have no rights under this Group Policy except as set forth in PART III, Section D, Article 2.

Article 10 - Electronic Transactions

Any transaction relating to this Group Policy may be conducted by electronic means if performance of the transaction is consistent with applicable state and federal law.

Any notice required by the provisions of this Group Policy given by electronic means will have the same force and effect as notice given in writing.

Article 11 - Value Added Service

The Principal reserves the right to offer or provide to a Policyholder a vision discount plan or any other value added service for the employees of the Policyholder. In addition, The Principal may arrange for third party service providers (i.e., optometrists, health clubs), to provide discounted goods and services to those Policyholders of The Principal. While The Principal has arranged these goods, services, and third party provider discounts, the third party service providers are liable to the Members for the provisions of such goods and services. The Principal is not responsible for the provision of such goods or services nor is it liable for the failure of the provision of the same. Further, The Principal is not liable to the Members for the negligent provisions of such goods and/or services by the third party service providers.

Section B - Premiums

Article 1 - Payment Responsibility; Due Dates; Grace Period

The Policyholder is responsible for collection and payment of all premium due while this Group Policy is in force. Payments must be sent to the home office of The Principal in Des Moines, Iowa.

Premium is due on the first day of each Premium Period. "Premium Period" means a monthly basis.

The first premium is due on the Date of Issue of this Group Policy. Each premium thereafter will be due on the first of each Insurance Month. Except for the first premium, a Grace Period of 31 days will be allowed for payment of premium. "Grace Period" means the first 31-day period following a premium due date. The Group Policy will remain in force until the end of the Grace Period, unless the Group Policy has been terminated by notice as described in this PART II, Section C. The Policyholder will be liable for payment of the premium for the time this Group Policy remains in force during the Grace Period.

Article 2 - Premium Rates

The premium rate for each Member insured for Dental Expense Insurance will be:

Member Without Dependents	$33.54
Member With One Dependent	$66.46
Member With Two or More Dependents	$131.65

If the Policyholder has at least two other eligible group insurance policies underwritten by The Principal, as determined by The Principal, the Policyholder may be eligible for a multiple policy discount.

Article 3 - Premium Rate Changes

The Principal may change a premium rate on any of the following dates:

a. on any premium due date, if the initial premium rate has then been in force 12 months or more and if Written notice is given to the Policyholder at least 31 days before the date of change; or

b. on any date the definition of Member or Dependent is changed; or

c. on any date that a schedule of insurance or class of insured Members is changed; or

d. on any premium due date, if the Policyholder has been receiving a multiple policy discount rate and the Policyholder drops below the minimum number of coverages to receive such discount rate.

If the Policyholder has other group insurance with The Principal, and if dental expense coverage is initially added on a date other than the Policy Anniversary and it is more than six months before the next Policy Anniversary, The Principal reserves the right to change the premium rate on the next Policy Anniversary. Written notice will be given to the Policyholder at least 31 days before the date of change.

If the Policyholder agrees to participate in the electronic services program of The Principal and, at a later date elects to withdraw from participation, such withdrawal may result in certain administrative fees being charged to the Policyholder.

Article 4 - Premium Amount

The amount of premium to be paid on each due date will be the sum of the premium rates then in effect for all Members then insured.

If a Member is added or a present Member's insurance is increased or terminated on other than the first of an Insurance Month, premium for that Member will be adjusted and applied as if the change were to take place on the first of the next following Insurance Month.

Article 5 - Contributions from Members

Members are required to contribute a portion of the premium for their insurance under this Group Policy.

Members are required to contribute a portion of the premium for their Dependent's insurance under this Group Policy.

Section C - Policy Termination

Article 1 - Failure to Pay Premium

This Group Policy will terminate at the end of the Grace Period if total premium due has not been received by The Principal before the end of the Grace Period. Failure by the Policyholder to pay the premium within the Grace Period will be deemed notice by the Policyholder to The Principal to discontinue this Group Policy at the end of the Grace Period.

Article 2 - Termination for Cause

The Principal may terminate this Group Policy for cause by giving the Policyholder 31 days advance notice in Writing, with "cause" defined to be:

a. the Policyholder ceases to be an eligible group as described in this PART II, Section A; or

b. the Policyholder has made a material misrepresentation to or committed an act of fraud against The Principal.

Article 3 - Termination Without Regard to Cause

The Policyholder may terminate this Group Policy effective on the day before any premium due date by giving Written notice to The Principal prior to that premium due date. The Policyholder's issuance of a stop-payment order for any amounts used to pay premiums for the Policyholder's insurance will be considered Written notice from the Policyholder.

The Principal may terminate this Group Policy without regard to cause by giving the Policyholder 31 days advance notice in Writing.

The Principal may terminate the Policyholder's coverage on any premium due date if the Policyholder relocates to a state where this Group Policy is not marketed, by giving the Policyholder 31 days advance notice in Writing.

Article 4 - Policyholder Responsibility to Members

If this Group Policy terminates for any reason, the Policyholder must:

a. notify each insured Member of the effective date of the termination; and

b. refund or otherwise account to each Member all contributions received or withheld from Members for premiums not actually paid to The Principal.

Section D - Policy Renewal

Article 1 - Renewal

Insurance under this Group Policy runs annually to the Policy Anniversary, unless sooner terminated.

While this Group Policy is in force, and subject to the provisions in this PART II, Section C, the Policyholder may renew at the applicable premium rates in effect on the Policy Anniversary.

PART III - INDIVIDUAL REQUIREMENTS AND RIGHTS

Section A - Eligibility

Article 1 - Member Dental Expense Insurance

A person will be eligible for Member Dental Expense Insurance on the later of:

a. the Date of Issue of this Group Policy; or

b. the date the person becomes a Member as defined in PART I.

If a Member elects to waive coverage under this Group Policy because he or she is covered under group dental expense coverage or coverages provided by the Dependent's employer, the date such coverage terminates because the Dependent is no longer eligible under his/her employer's coverage will be considered the date the Member is eligible to request insurance as described in PART III, Section B of this Group Policy.

Article 2 - Dependent Dental Expense Insurance

A person will be eligible for Dependent Dental Expense Insurance on the latest of:

a. the date the person is eligible for Member Dental Expense Insurance; or

b. the date the person first acquires a Dependent.

If a Member's Dependent is employed and covered under group dental expense coverage or coverages provided by the Dependent's employer, the date such coverage terminates because the Dependent is no longer eligible under his/her employer's coverage will be considered the date the Member first acquires that Dependent (and any other Dependent who was also covered under such group coverage or coverages).

Section B - Effective Dates

Article 1 - Member Dental Expense Insurance

a. Actively at Work

A Member's effective date for Member Dental Expense Insurance will be as explained in this article, if the Member is Actively at Work on that date. If the Member is not Actively at Work on the date insurance would otherwise be effective, such insurance will not be in force until the day of return to Active Work.

This Actively at Work requirement will be waived for Members who:

(1) are absent from Active Work because of a regularly scheduled day off, holiday, or vacation day; and
(2) were Actively at Work on their last scheduled work day before the date of their absence; and
(3) were capable of Active Work on the day before the scheduled effective date of their insurance or change in their insurance, whichever is applicable.

b. Effective Date for Noncontributory Insurance

Insurance for which the Member contributes no part of premium will be in force on the date the Member is eligible.

c. Effective Date for Contributory Insurance

If a Member is to contribute a part of premium, insurance must be requested in a form approved by The Principal. The effective date of requested insurance will be based on the Member's date of request.

(1) Request on or before the date eligible or within 31 days after the date eligible

Insurance will be in force on the date the Member is eligible if request is made on or before the date the Member is eligible or if coverage is requested within 31 days of the date the Member is eligible.

(2) Request more than 31 days after the date eligible

Insurance will be in force on the first Policy Anniversary date following the date of the Member's request.

(3) Request more than 31 days after the date insurance terminates at the Member's request

Insurance will be in force on the next Policy Anniversary date following the date of the Member's request.

d. Annual Enrollment Period

An Annual Enrollment Period will be available for any Member or Dependent who failed to enroll:

(1) during the first period in which he or she was eligible to enroll, or during any subsequent Special Enrollment Period, as described in f. below; or
(2) during any previous Annual Enrollment Period; or
(3) within 31 days after the termination date, if the individual was previously insured under this Group Policy but elected to terminate such insurance.

To qualify for enrollment during the Annual Enrollment Period, the Member or Dependent:

(1) must meet the eligibility requirements described in this Group Policy, including satisfaction of any applicable waiting period; and
(2) may not be covered under an alternate dental expense plan offered by the Policyholder unless the Annual Enrollment Period happens to coincide with a separate open enrollment period established for coverage election.

The Annual Enrollment Period is generally the one-month period immediately prior to the Policy Anniversary date or another period of time requested by the Policyholder and accepted by The Principal.

The effective date for any such individual requesting insurance during the Annual Enrollment Period will be the Policy Anniversary date following completion of the Annual Enrollment Period provided premium has been paid for the requested insurance.

e. Court Ordered Coverage Under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN): This section will apply to a Member or Dependent Child if:

(1) the Member is enrolled (or is eligible to be enrolled but has failed to enroll during a previous enrollment period); and
(2) the Member has failed to enroll the Dependent Child during a previous enrollment period; and
(3) the Member is required by a QMCSO or NMSN as defined by applicable federal law and state insurance laws to provide dental coverage for the Dependent Child.

The request for enrollment:

(1) may be made at any time after the issue date of the QMCSO or NMSN; and
(2) will apply only to the Member and/or Dependent Child(ren) listed in the QMCSO or NMSN.

If the Policyholder offers employees a choice among dental benefit coverages, the Member may elect to transfer from another of the offered coverages to coverage under this Group Policy when requesting enrollment due to a QMCSO or NMSN.

The effective date of the Member's or Dependent Child's insurance:

(1) will be the date of the request for enrollment; and
(2) will not be subject to the Actively at Work provisions described in this section.

A request for enrollment for any Dependent not listed in the QMCSO or NMSN will be subject to the regular effective date provisions of this Group Policy.

f. Special Enrollment Period

A Special Enrollment Period, as described below, will be available for a Member or Dependent if enrollment is made after the first period in which the individual was eligible to enroll.

The Special Enrollment Periods are:

(1) Loss of Other Coverage: A Special Enrollment Period will apply to a Member or Dependent if all of the following conditions are met:

(i) the individual (Member or Dependent) was covered under another group dental expense coverage at the time of his or her initial eligibility, and declined enrollment solely due to the other coverage; and
(ii) the other coverage terminated due to loss of eligibility (including loss due to divorce or legal separation, death, termination of employment or reduction in work hours, or, if the other coverage was under COBRA or state continuation provision, due to exhaustion of the continuation); and
(iii) request for enrollment is made within 31 days after the other coverage terminates.

The effective date of insurance will be the date of the request for enrollment provided premium has been paid for the requested insurance.

NOTE: For the purpose of (1) (ii) above:

"Loss of eligibility" does not include:

(i) a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the dental expense coverage); or
(ii) a loss due to a spouse's voluntary termination of his or her dental expense coverage; or
(iii) a loss due to a spouse's voluntary termination of his or her Dependent dental expense coverage.

(2) Newly Acquired Dependents: A Special Enrollment Period will apply to a Member or Dependent if:

(i) the Member is enrolled (or is eligible to be enrolled but has failed to enroll during a previous enrollment period); and
(ii) a person becomes a Dependent of the Member through marriage, birth, adoption or Placement for Adoption; and
(iii) request for enrollment is made within 31 days after the date of the marriage, birth, adoption or Placement for Adoption, or the date Dependent Dental Expense Insurance is available to the Member under this Group Policy, if the request is made on or before the event or within 31 days after the event.

The effective date of the Member's or Dependent's insurance will be:

(i) in the event of marriage, the date of such marriage; or
(ii) in the event of a Dependent Child's birth, the date of such birth; or
(iii) in the event of a Dependent Child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption, whichever is earlier.

g. Effective Date for Benefit Changes - Change in Member Status

A change in a Member's Scheduled Benefits because of a change in the Member's status (insurance class) will normally be effective on the date of the change in status. However, if the Member is not Actively at Work on the date a Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the date the Member returns to Active Work.

Any termination of Scheduled Benefits due to a change in a Member's status (insurance class) will be effective on the date of the change in status, whether or not the Member is Actively at Work.

h. Effective Date for Benefit Changes - Change by Policy Amendment

A change in the amount of a Member's Scheduled Benefits because of a change in the Schedule of Insurance (as described in PART IV, Section A) by amendment to this Group Policy will be effective on the date of change. However, if the Member is not Actively at Work on the date a Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the date the Member returns to Active Work.

i. Effective Date for Benefit Changes - Change in Benefits Made by The Principal

A change in a Member's Scheduled Benefits because of a change made by The Principal will normally be effective on the Policyholder's Policy Anniversary (or as otherwise determined by The Principal). However, if the Member is not Actively at Work on the date a Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the date the Member returns to Active Work.

Article 2 - Dependent Dental Expense Insurance

Dependent Dental Expense Insurance is available only with respect to Dependents of Members currently insured for Member Dental Expense Insurance. If a Member is eligible for Dependent Dental Expense Insurance, such insurance will be effective under the same terms as set forth for Member Dental Expense Insurance in this Section B, Article 1 except:

a. A Member will be insured with respect to a new Dependent on the date the Dependent is acquired, if Dependent Dental Expense Insurance is then in force for any other Dependent of the Member.

b. The Actively at Work requirement will apply only to Member insurance.

Section C - Individual Terminations

Article 1 - Member Dental Expense Insurance

Unless continued as provided in Section D - Continuation, a Member's coverage under this Group Policy will terminate on the earliest of:

a. the date this Group Policy is terminated; or

b. the date the last premium is paid for the Member's insurance; or

c. for contributory insurance, any date desired, if requested by the Member before that date; or

d. the date the Member ceases to be a Member as defined in PART I; or

e. the date the Member ceases to be in a class for which Member Dental Expense Insurance is provided; or

f. the date the Member ceases Active Work.

Article 2 - Dependent Dental Expense Insurance

Unless continued as provided in Section D - Continuation, a Member's coverage under this Group Policy for a Dependent will terminate on the earliest of:

a. the date his or her Member Dental Expense Insurance terminates; or

b. the date Dependent Dental Expense Insurance is removed from this Group Policy; or

c. the date the last premium is paid for the Member's Dependent Dental Expense Insurance; or

d. for contributory insurance, any date desired, if requested by the Member before that date; or

e. the date the Member ceases to be in a class for which Dependent Dental Expense Insurance is provided; or

f. for each spouse or Dependent Child, on the date that spouse or Dependent Child ceases to be a Dependent as defined in PART I. However, a spouse who no longer resides with the Member will not cease to be a Dependent until legally separated or divorced, provided the spouse otherwise continues to be a Dependent as defined in PART I.

Section D - Continuation

Article 1 - Member Dental Expense Insurance

a. Sickness or Injury

If Active Work ends because a Member is sick or injured, insurance for that Member may be continued until the earliest of:

(1) the date insurance would otherwise cease as provided in PART III, Section C; or
(2) the date the Member recovers; or
(3) the date the Member is covered under the USERRA continuation provision; or
(4) coverage has been continued under this Section for 12 consecutive months.

If coverage under this Group Policy is continued under either COBRA or a state continuation mandate, the continuation coverage provided under this subsection will run concurrently with the COBRA or state continuation.

b. Layoff or Approved Leave of Absence

If Active Work ends because a Member is on layoff or approved leave of absence, insurance for that Member may be continued until the earliest of:

(1) the date insurance would otherwise cease as provided in PART III, Section C; or
(2) the date the layoff or approved leave of absence ends; or
(3) the date the Member becomes eligible for any other group dental expense coverage; or
(4) the date one month after the date Active Work ends.

If coverage under this Group Policy is continued under either COBRA or a state continuation mandate, the continuation coverage provided under this subsection will run concurrently with the COBRA or state continuation.

c. State Required - Vermont

A Member's Dental Expense Insurance may also be continued as described in Article 3, State Required Continuation.

Article 2 - Dependent Dental Expense Insurance

a. During Continuation of Member Insurance

Except as otherwise provided in PART III, Section C, Dependent Dental Expense Insurance may remain in force during any period that Member Dental Expense Insurance is continued.

b. Developmentally Disabled or Physically or Mentally Incapacitated

(1) Qualification

Dental Expense Insurance for a child may be continued after the child reaches the maximum age for Dependent Children as defined in PART I of this Group Policy, provided that:

- the child is incapable of self-support as the result of a Developmental Disability or Physical or Mental Incapacity and became so before reaching the maximum age and is dependent on the Member for primary support; and
- except for age, the child continues to be a Dependent Child as defined in PART I; and
- proof of the child's incapacity is sent to The Principal within 31 days after the date the child reaches the maximum age; and
- further proof that the child remains incapable of self-support is provided when The Principal requests; and
- the child undergoes examination by a Physician when The Principal requests. The Principal will pay for these examinations and will choose the Physician to perform them.

(2) Period of Continuation

Insurance for a Dependent Child who qualifies as set forth above may be continued until the earlier of:

- the date insurance would cease for any reason other than the child's attainment of the maximum age; or
- the date the child becomes capable of self-support or otherwise fails to qualify as set forth in (1) above.

c. State Required - Vermont

A Dependent's Dental Expense Insurance may also be continued as described in Article 3, State Required Continuation.

Article 3 - State Required Continuation - Vermont

a. Member or Dependent Continuation

(1) Definitions

Qualified Person means an individual who, on the day before a Qualifying Event, is covered under this Group Policy by virtue of being the Member or the Dependent spouse or Dependent Child of a Member.

Qualifying Event means any of the following events which, except for the election to continue coverage, would result in a loss of coverage to a Qualified Person:

- the Member's termination of employment, including a reduction in hours that results in ineligibility for coverage. In this instance, covered Dependents are eligible for continuation of coverage only if the Member has elected to continue coverage under these provisions; or
- the Member's death; or
- the Member's divorce, dissolution or legal separation from his or her spouse; or
- the Dependent Child ceases to meet the requirements for a Dependent Child.

(2) Qualification for Continuation

A Qualified Person who would lose insurance under this Group Policy because of a Qualifying Event may elect to continue the insurance if, on the date insurance would otherwise cease:

- the Qualified Person is covered under this Group Policy on the date of the Qualifying Event; and
- the Qualified Person is not covered by Medicare; and
- the Qualified Person is not covered by any other group insured or uninsured arrangement that provides dental coverage for individuals in a group, under which the person was not covered immediately before the occurrence of a Qualifying Event and preexisting condition exclusion applies; and
- this Group Policy is in force.

Election is subject to the Notice, Election, and Premium requirements described below. If continuation is elected, all applicable terms and conditions of this Group Policy will apply to the continued insurance.

(3) Period of Continuation

Insurance for a Qualified Person who qualifies as described above may be continued until the earliest of:

- the date this Group Policy is terminated (the Qualified Person may complete the continuation period under the Policyholder's replacement coverage, if any); or

- the date the Qualified Person first becomes covered (after electing continuation) under another group dental expense plan and no preexisting condition exclusion applies; or
- the date insurance would otherwise cease as provided in this PART III, Section C; or
- the end of the period for which premium is paid, if the Qualified Person fails to make timely payment of a required premium; or
- the date insurance has been continued for 18 months.

(4) Notice, Election, and Premium Requirement

The Policyholder must give the Member Written notice of the continuation right within 30 days after the date insurance would otherwise terminate. The Member must give Us Written notice of his/her election to continue, and must pay the first premium, within 60 days after the later of:

- the date the insurance would otherwise cease; or
- the date the Member receives Written notice.

b. Dependent Continuation: Students on a Medical Leave of Absence

(1) Qualification for Continuation

If a child's insurance would otherwise end because he or she ceases to qualify as a Full-Time Student as defined in PART I of this Group Policy due to a medical condition, the child's insurance must continue provided:

- The Principal has received Written certification Signed by his or her treating Physician that the child's absence from school is medically necessary; and
- the Group Policy is in force; and
- the child is not eligible for Medicare or other group medical expense coverage.

(2) Period of Continuation

Such continued insurance will terminate on the earliest of:

- the date the child reaches the maximum age for a Full-Time Student; or
- the certification period for the medically necessary leave of absence has expired and no further certification was provided 15 days prior to the expiration of the certification period; or
- 24 months has elapsed since the child's coverage continuation began and the child has not returned to school full-time; or
- the child advises The Principal that he or she does not intend to return to school full-time; or

- the child obtains coverage under Medicare or other group medical expense coverage; or
- the date the child fails to qualify as set forth in (1) above; or
- the date the insurance would otherwise cease as provided in PART III, Section C.

Article 4 - Federal Required Continuation

a. Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA applies to any employer (excepting the federal government and religious organizations) who:

(1) maintains a group dental coverage; and
(2) normally employed 20 or more employees on a typical business day during the preceding Calendar Year. For this purpose, "employee" means full-time employees and full-time equivalent for part-time employees.

Federal law requires that certain group health plans allow qualified persons who would otherwise lose coverage under this Group Policy as a result of a qualifying event, to elect to continue group coverage under this Group Policy. If coverage under this Group Policy is continued under Article 1, Article 2, or Article 3 above, the continuation coverage provided under COBRA will run concurrently with such continuation provisions.

A full description of the COBRA continuation provisions is included in the administration material provided to the Policyholder and in the booklet-certificate.

b. Family and Medical Leave Act (FMLA)

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects this Group Policy. A full description of the FMLA continuation provisions is included in the administration material provided to the Policyholder.

(1) FMLA and Other Continuation Provisions

These FMLA continuation provisions:

- are in addition to any other continuation provisions described in this Group Policy, if any; and

- will run concurrently with any other continuation provisions described in this Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

(2) Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding Calendar Year.

(3) Eligible Employee

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and
- for at least 1,250 hours during the year preceding the start of the leave; and
- at a worksite where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

(4) Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- the birth of a child of an Eligible Employee and in order to care for the child;
- the placement of a child with the Eligible Employee for adoption or foster care;
- to care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition";
- a "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job; or
- because of a "qualifying exigency" arising out of a spouse, son, daughter or parent on active duty to a foreign country or having been notified of a call to active duty.

Eligible Employers are required to allow up to a total of 26 workweeks of unpaid leave during any 12-month period to eligible employees to care for a "covered military member" with a "serious injury or illness". Covered military member means a current member of the Armed Forces and the National Guard or Reserves. It also includes a covered veteran who was a member of the Armed Forces (including a member of the National Guard or Reserves), and was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date an employee takes FMLA leave.

Eligible Employers are required to allow 15 days of unpaid leave during any 12-month period to eligible employees to spend time with a military member on "rest and recuperation" leave.

(5) Reinstatement

An Eligible Employee's terminated insurance may be reinstated in accordance with the provisions of the FMLA, subject to the Actively at Work provisions described in PART III, Section B.

c. Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA)

Federal law requires that if a Member's insurance would otherwise end because he or she enters into active military duty or inactive military duty for training, the Member may elect to continue insurance (including Dependents insurance) in accordance with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Such continued insurance will terminate on the earliest of:

(1) for a Member and his or her Dependents:

- the date this Group Policy is terminated; or
- the end of the premium period for which premium is paid if the Member fails to make timely payment of a required premium; or
- the date 24 months after the date the Member enters active military duty; or
- the date after the day in which the Member fails to return to Active Work or apply for reemployment with the Policyholder.

(2) for a Member's Dependents:

- the date Dependent Dental Expense Insurance would otherwise cease as provided in PART III, Section C; or
- any date desired, if requested by the Member before that date.

Continuation provisions described in this Group Policy for sickness, injury, layoff, or approved leave of absence, if any, may apply. These continuation provisions, however, will terminate on the date the Member is covered under the USERRA continuation provision. If the Member qualifies for USERRA, COBRA, or state continuation, the election of one means the rejection of the other.

The reinstatement time period, as provided in this PART III, Section E, may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA. The Actively at Work provisions, described in PART III, Section B, will not apply to the reinstated insurance.

This is a general summary of the USERRA and how it affects this Group Policy. A full description of the USERRA continuation provisions is included in the administration material provided to the Policyholder.

Section E - Reinstatement

Article 1 - Reinstatement

A Member's terminated insurance will be reinstated if:

a. insurance ceased because of layoff or approved leave of absence; and

b. the Member returns to Active Work for the Policyholder within six months of the date insurance ceased.

The Member's reinstated insurance will be in force on the date of return to Active Work. However, the Actively at Work provision discussed in PART III, Section B, will apply.

Only the period of time during which a Member is actually insured will be included in determining the length of his or her continuous coverage under this Group Policy. For this purpose the period of time during which a reinstated Member's insurance was not in force:

a. will not be considered an interruption of continuous coverage; and

b. will not be used to satisfy any provision of this Group Policy which pertains to a period of continuous coverage.

PART IV - BENEFITS

Section A - Dental Expense Insurance (General Provisions)

Article 1 - Schedule of Insurance

a. Insurance Class

Subject to the Effective Date provisions of PART III, Section B, Scheduled Benefits for Members and Dependents will be:

Class	Scheduled Benefits
All Members and All Dependent spouses	Dental benefits as described in this PART IV, Section B (1), for Covered Charges under Dental Care Units 1, 2, and 3.
All Dependent Children	Dental benefits as described in this PART IV, Section B (1), for Covered Charges under Dental Care Units 1, 2, 3, and 4.

b. Dental Care Units

Treatment or Service for which benefits are payable under this Group Policy are divided into Dental Care Units:

Preventive Procedures	Unit 1
Basic Procedures	Unit 2
Major Procedures	Unit 3
Orthodontia	Unit 4

c. Maximum Benefits

Benefit payment provided under this PART IV, Section B (1), for a Member or Dependent will not exceed:

Covered Charges	Maximum Payment Limit
Dental Care Units 1, 2, and 3	$1,200 each Calendar Year for dental care received from Preferred Providers and $1,200 for Non-Preferred Providers (in combination)

Dental Care Unit 4	$1,750 lifetime for dental care received from Preferred Providers and $1,750 for Non-Preferred Providers (in combination)

Covered Charges used to satisfy the maximum that applies when care is received from PPO Providers will be used in combination with care received from Non-PPO Providers to satisfy the maximum.

For Dental Care Unit(s) 1, 2 and 3, at the end of each Calendar Year, if the Member or Dependent has:

a. received at least one procedure performed during that Calendar Year; and

b. used $600 or less of benefits during the Calendar Year;

the balance of any unused benefits or any difference between paid claims and up to 50% of the amount in b. above for each Member or Dependent will carry-over ("roll-over") into the next Calendar Year. These benefits will be combined with the Maximum Payment Limit for the current Calendar Year and will be payable at the same level up to a maximum amount of $1,200. In the event that a. above is not satisfied in any year, any current or previous amount carried over will be forfeited.

This carry-over provision does not apply:

a. during the first Calendar Year for any individual having an initial coverage effective date in October, November or December; or

b. until all waiting periods have been satisfied.

Article 2 - Benefit Qualification

A Member or Dependent will qualify for payment of the benefits provided for an insurance class if:

a. he or she is insured in that class on the date dental Treatment or Service is received; and

b. the claim requirements of PART IV, Section C, are satisfied.

Article 3 - Benefits Payable

Benefits payable under this Group Policy will be as described in PART IV, Section B (1), subject to:

a. the limitations listed in PART IV, Section B (1B); and

b. the terms and conditions set forth in PART IV, Section D.

Section B (1) - Dental Expense Insurance (PPO)

Article 1 - Payment Conditions

If a Member or Dependent receives any Treatment or Service that is listed in this PART IV under the Schedule of Dental Procedures, The Principal will pay the charges for that Treatment or Service. The benefits payable for all listed Treatment or Service received will be as described below.

The total benefit payment for each Member and Dependent will not be more than the Dental Maximum Payment Limit(s).

a. Preferred Providers

If dental care is received from Preferred Providers, benefits payable will be:

(1) Dental Care Unit 1

100% of Covered Charges each Calendar Year described in this section.

(2) Dental Care Unit 2

90% of Covered Charges each Calendar Year in excess of the Deductible Amount described in this section.

(3) Dental Care Unit 3

60% of Covered Charges each Calendar Year in excess of the Deductible Amount described in this section.

(4) Dental Care Unit 4

50% of Covered Charges up to the lifetime Maximum Payment Limit described in this section.

b. Non-Preferred Providers

If dental care is received from Non-Preferred Providers, benefits payable will be:

(1) Dental Care Unit 1

100% of Covered Charges each Calendar Year described in this section.

(2) Dental Care Unit 2

80% of Covered Charges each Calendar Year in excess of the Deductible Amount described in this section.

(3) Dental Care Unit 3

50% of Covered Charges each Calendar Year in excess of the Deductible Amount described in this section.

(4) Dental Care Unit 4

50% of Covered Charges up to the lifetime Maximum Payment Limit described in this section.

Article 2 - Deductible Amount

a. Preferred Providers - Individual

If dental care is received from Preferred Providers, the individual Deductible Amount for each Member or Dependent each Calendar Year will be:

(1) none with respect to Covered Charges under Dental Care Unit 1; and
(2) $25 with respect to Covered Charges under Dental Care Units 2 and 3 (in combination) each Calendar Year; and
(3) none with respect to Covered Charges under Dental Care Unit 4.

b. Preferred Providers - Family Maximum

If dental care is received from Preferred Providers, the maximum combined Deductible Amount for all persons in the same family (a Member and his or her Dependents) each Calendar Year will be:

(1) none with respect to Covered Charges under Dental Care Unit 1; and
(2) $50 with respect to the combined Member and Dependent total of Covered Charges under Dental Care Units 2 and 3 (in combination) each Calendar Year; but not counting more than $25 of such Covered Charges for each person in the family; and
(3) none with respect to Covered Charges under Dental Care Unit 4.

When the family maximum Deductible is satisfied, benefits will be payable as if the individual Deductibles for each person in the family had been satisfied for the Calendar Year.

c. Non-Preferred Providers - Individual

If dental care is received from Non-Preferred Providers, the individual Deductible Amount for each Member or Dependent each Calendar Year will be:

(1) none with respect to Covered Charges under Dental Care Unit 1; and
(2) $25 with respect to Covered Charges under Dental Care Units 2 and 3 (in combination) each Calendar Year; and
(3) none with respect to Covered Charges under Dental Care Unit 4.

d. Non-Preferred Providers - Family Maximum

If dental care is received from Non-Preferred Providers, the maximum combined Deductible Amount for all persons in the same family (a Member and his or her Dependents) each Calendar Year will be:

(1) none with respect to Covered Charges under Dental Care Unit 1; and
(2) $50 with respect to the combined Member and Dependent total of Covered Charges under Dental Care Units 2 and 3 (in combination) each Calendar Year; but not counting more than $25 of such Covered Charges for each person in the family; and
(3) none with respect to Covered Charges under Dental Care Unit 4.

When the family maximum Deductible is satisfied, benefits will be payable as if the individual Deductibles for each person in the family had been satisfied for the Calendar Year.

For each Dental Care Unit, Covered Charges used to satisfy the Deductible that is applicable when care is received from Non-Preferred Providers for the Calendar Year will be counted toward satisfaction of the Deductible that is applicable when care is received from Preferred Providers for the Calendar Year, and vice versa.

In no event will the individual Deductible for combined Preferred Providers and Non-Preferred Providers be more than the Non-Preferred Providers Deductible Amount for the Calendar Year.

Charges are applied to the Deductible Amount in the order in which they are incurred. However, if Covered Charges are incurred for Units 2 and 3 on the same date, the charges will be applied to the Deductible Amount in the following order:

(1) first, to Unit 2 charges; and
(2) then, to Unit 3 charges.

Article 3 - Covered Charges

Covered Charges will be the actual cost charged to the Member or Dependent for Treatment or Service for the listed procedures described in this section under the Schedule of Dental Procedures but only to the extent that the actual cost charged does not exceed Prevailing Charges. Also:

a. if The Principal determines that more than one procedure could be performed to correct a dental condition, Covered Charges will be limited to the Prevailing Charge for the least expensive of the procedures that would provide professionally acceptable results; and

b. Covered Charges will include only those charges for Treatment or Service that begin (see Article 4 below) while the Member or Dependent is insured under this Group Policy; and

c. Covered Charges will include only those charges for Treatment or Service that is completed while the Member or Dependent is insured under this Group Policy, except when the Treatment or Service is covered under the Extended Benefits provision described in Article 6 below.

Article 4 - Beginning Date for Treatment or Service

Treatment or Service will be considered to begin on the applicable date shown below:

a. for root canal therapy, on the date the pulp chamber is opened and the pulp canal explored to the apex; and

b. for crowns, fixed bridgework, inlays, or onlay restoration, on the date the tooth or teeth are fully prepared; and

c. for complete or partial dentures, on the date the master impression is made; and

d. for orthodontia, on the date the appliance or bands are first set; and

e. for all other, on the date the Treatment or Service is performed.

Article 5 - Completion Date for Treatment or Service

Treatment or Service will be considered to be completed on the applicable date shown below:

a. for root canal therapy, on the date the tooth is sealed; and

b. for crowns, on the date the crown is seated; and

c. for fixed bridgework, on the date the bridge is seated; and

d. for inlay or onlay restorations, on the date the inlay or onlay is seated; and

e. for complete or partial dentures, on the date the complete or partial denture is seated.

Article 6 - Extended Benefits

a. Applicability

The Principal will pay Dental benefits for Treatment or Service described in b. below that is received by a Member or Dependent within 30 days after his or her insurance under this Group Policy is terminated, provided that:

(1) the Member or Dependent would have qualified for benefit payment under this section if insurance had remained in force; and
(2) the Treatment or Service began while the Member or Dependent was insured under this Group Policy; and
(3) at the time Treatment or Service is received, this Group Policy is in force.

However, no benefits will be paid for Treatment or Service received on or after the date the Member or Dependent becomes eligible for other group dental expense coverage, unless Written documentation is provided that Treatment or Service began while the Member or Dependent was insured under this Group Policy and the preceding carrier will not provide coverage for the completed Treatment or Service.

b. Qualified Treatment or Service

If the requirements of a. above are satisfied, extended benefits will be payable for:

(1) root canal therapy, but only if the pulp chamber was opened and the pulp canal explored to the apex while the Member or Dependent was insured under this Group Policy; and
(2) crowns, bridges, inlays, or onlay restorations, but only if the tooth or teeth were fully prepared while the Member or Dependent was insured under this Group Policy; and
(3) complete or partial dentures, but only if the master impression was made while the Member or Dependent was insured under this Group Policy.

Section B (1B) - Dental Expense Insurance - Limitations

Article 1 - Limitations

Covered Charges will not include and no benefits will be paid for:

a. Treatment or Service that is not a Covered Charge; or

b. the services of any person who is not a Dentist or Dental Hygienist; or

c. any part of a charge for Treatment or Service that exceeds Prevailing Charges; or

d. the services of any person who is in an insured person's Immediate Family; or

e. implants, except as provided under Coverage for Dental Implants; or

f. Treatment or Service that does not meet professionally recognized standards of quality; or

g. veneers, anterior 3/4 cast crowns, personalization of dentures or crowns and any other Treatment or Service that is primarily cosmetic; or

h. drugs, medicines, or therapeutic drug injections; or

i. instructions for plaque control, oral hygiene, or diet; or

j. bite registration or occlusal analysis; or

k. Treatment or Service to alter or maintain vertical dimension or restore or maintain occlusion; or

l. Treatment or Service for the purpose of duplicating a prosthetic device or replacing any such device that is lost or stolen; or

m. Treatment or Service for the purpose of duplicating an appliance or replacing any such appliance that is lost or stolen; or

n. Orthodontic Treatment or Service; if the appliance or bands were placed prior to being insured under this Group Policy, unless the Dependent Child is currently in a treatment plan which was covered under prior group orthodontic coverage, and there has been no Lapse in Coverage; or

o. Treatment or Service for provisional or permanent splinting; or

p. Treatment or Service for which the Member or Dependent has no financial liability or that would be provided at no charge or at a different charge in the absence of insurance; or

q. Treatment or Service that is temporary; or

r. Treatment or Service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or

s. Treatment or Service that results from a sickness that is covered by a Workers' Compensation Act or other similar law; or

t. Treatment or Service that results from an injury arising from or in the course of any employment for wage or profit; except this limitation will not apply to: partners, proprietors, or corporate officers of the Policyholder who are not covered by a Workers' Compensation Act or other similar law; or

u. Treatment or Service that results from war or act of war; or

v. Treatment or Service that results from participation in criminal activities; or

w. Treatment or Service provided outside the United States, unless the Member or Dependent are outside the United States for one of the following reasons:

(1) travel, provided the travel is for a reason other than securing dental care diagnosis or treatment; or
(2) a business assignment, provided the Member or Dependent are temporarily outside the United States; or
(3) full-time student status, provided the student is either:

- enrolled and attending an accredited school in a foreign country; or
- is participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit; or

(4) Mormon missionary work of a Dependent Child; or

x. Treatment or Service replacing tooth structure lost from abrasion, attrition, erosion, or abfraction; or

y. Treatment or Service which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years; or

z. Treatment or Service that is an Experimental or Investigational Measure. (The denial of any claim on the basis of the exclusion of coverage for experimental or investigational Treatment or Service may be appealed through the procedure described in the notice of that claim decision); or

aa. Treatment or Service that is paid for by a Medicare Supplement Insurance Plan; or

ab. Treatment or Service for temporomandibular joint disorders; or

ac. charges by an anesthesiologist for services that were performed in facilities other than a dental office; or

ad. emergency room charges or outpatient facility charges (including but not limited to hospital outpatient facility charges); or

ae. Treatment or Service for patient management (including but not limited to nitrous oxide and analgesia), local anesthetic and general anesthesia and IV sedation, except as otherwise provided in this Group Policy; or

af. Occlusal guards; or

ag. charges that are billed incorrectly or separately for Treatment or Services that are an integral part of another billed Treatment or Service as determined by The Principal.

Section B (2) - Dental Expense Insurance - Schedule of Dental Procedures - Unit 1

Article 1 - Schedule of Dental Procedures

Unless The Principal agrees otherwise, Covered Charges will include only charges for procedures listed in this PART IV, Section B (2). If a non-listed procedure is accepted, The Principal will determine its maximum allowance based on the Prevailing Charges for a listed procedure of comparable nature.

Article 2 - Dental Care Unit 1 - Preventive Procedures

Covered Charges will be the actual cost charged to the Member or Dependent for Treatment or Service for the listed procedures described in this article but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Dental Procedure

Examinations

Only one of the below listed procedures will be covered in any six consecutive month period.

Oral examination (evaluation)

Periodic examination (evaluation)

Office visit

Second Opinion

Benefits will be payable for a Second Opinion obtained with respect to a recommended Treatment or Service at 100% of Second Opinion Consultation Charges, subject to Prevailing Charges.

Note: Obtaining a confirming Second Opinion does not guarantee payment of the Treatment or Service. All other terms, provisions, conditions, limitations, and exclusions of this Group Policy remain in full force and effect with respect to benefits.

Radiographs

Full Mouth Survey

Complete series (including bitewings)

Panoramic

Only one of the listed full mouth surveys will be covered in any 60 consecutive month period.

Bitewing

Only one set will be covered in any Calendar Year.

Occlusal

Only two films will be covered in any Calendar Year.

Periapical

Only four films will be covered in any Calendar Year.

Extraoral X-Rays

Sialography
Cephalometric film
Posterior-anterior or lateral skull and facial bone survey

Only two of the listed extraoral procedures will be covered in any 12 consecutive month period.

Diagnostic x-rays performed in conjunction with root canal therapy or orthodontic treatment will not be considered Unit 1 Covered Charges

Preventive Services

Prophylaxis (cleaning of teeth)

Covered once in any six consecutive month period.

Topical application of fluoride

Applicable only to Dependent Children under the age of 19. Only one application(s) will be covered in any Calendar Year.

Topical application of sealants

Applicable only to first and second permanent molars for Dependent Children under age 19. Covered once each tooth in any 36 consecutive month period.

Other Services

Harmful Habit Appliance

Limited to one time per person under age 19.

Space maintainers

Applicable only to Dependent Children under age 19. Repairs to space maintainers are not covered. Limited to one bilateral space maintainer per arch or one unilateral space maintainer per quadrant.

Section B (3) - Dental Expense Insurance - Schedule of Dental Procedures - Unit 2

Article 1 - Schedule of Dental Procedures

Unless The Principal agrees otherwise, Covered Charges will include only charges for procedures listed in this PART IV, Section B (3). If a non-listed procedure is accepted, The Principal will determine its maximum allowance based on the Prevailing Charges for a listed procedure of comparable nature.

Article 2 - Dental Care Unit 2 - Basic Procedures

Covered Charges will be the actual cost charged to the Member or Dependent for Treatment or Service for the listed procedures described in this article but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Dental Procedure

Restorations

Fillings (amalgam or resin-based composite)

Anterior

Mesial-lingual, distal-lingual, mesial-buccal, and distal buccal restoration will be considered single surface restorations.

Multiple restorations on adjacent surfaces of the same tooth are considered connected. Benefits will be based on the benefit for a single restoration reflecting the number of different surfaces.

Multiple restorations on the same surface of the same tooth will be based on the benefit for a single surface restoration.

Posterior

Multiple restorations on adjacent surfaces of the same tooth are considered connected. Benefits will be based on the benefit for a single restoration reflecting the number of different surfaces.

Multiple restorations on the same surface of the same tooth will be based on the benefit for a single surface restoration.

Replacement

Replacement of existing fillings are covered only if at least 24 consecutive months have passed since placement of prior fillings, unless required by new decay in an additional tooth surface.

Benefits for composite restorations on posterior teeth will be based on the benefits for the corresponding amalgam restorations.

Stainless Steel Crown
Prefabricated Resin Crown

> For Dependent Children under the age of 19, only one of the listed crowns will be covered in any 24 consecutive month period. If a stainless steel or Prefabricated Resin Crown is used for an adult in lieu of a permanent crown, all replacement restrictions will be as listed for permanent crowns in Section B (4). If a permanent crown replaces a crown listed in this section at a later date but before replacement restrictions allow, all new charges will be reduced by those already paid.

Endodontic Services

Vital pulpotomy

> Covered for deciduous teeth only.

Root canal therapy including treatment plan, intra-operative x-rays, clinical procedures, and follow-up care. Retreatment of previous root canal therapy covered once per tooth per lifetime.

Apexification
Apicoectomy - Covered once per root per lifetime
Retrograde filling - Covered once per root per lifetime
Root amputation
Root resection
Hemisection

Periodontic Services

Scaling and root planing (each quadrant)

> Covered once each quadrant in any 24 consecutive month period.
>
> Note: If the Member or Dependent is pregnant, diabetic or has heart disease, scaling and root planing will be paid at 100% and one additional routine cleaning or periodontal cleaning will be allowed.

Full Mouth Debridement

Covered once per lifetime. Only covered if no other service (other than x-rays) is provided during the visit.

Periodontal Prophylaxis (includes probing, charting, polishing, scaling, root planing, and similar maintenance procedures).

Covered only if at least three months have elapsed after completion of covered active therapeutic scaling and root planing or covered active surgical periodontal treatment and then not more than once in any six consecutive month period.

Periodontal Surgical Procedures

Gingival flap procedure
Gingivectomy
Osseous surgery
Pedicle soft tissue graft
Free soft tissue graft
Subepithelial connective tissue graft
Distal or proximal wedge procedure
Crown lengthening

Only one of the listed periodontic surgical procedures is covered for each quadrant in any 36 consecutive month period.

Bone Replacement Graft

Covered once per site per lifetime.

Oral Surgery

Simple extraction
Surgical removal of erupted tooth
Root removal - exposed roots

There will be no separate benefit payable for bone grafting of an extraction site.

Incision and drainage of dental abscess
Biopsy of soft tissue

Other Oral Surgical Procedures

Extraction of impacted teeth (soft tissue, partial bony, complete bony)
Surgical root removal

There will be no separate benefit payable for bone grafting of an extraction site.

Alveoplasty
Removal of exostosis
Removal of palatal torus
Removal of mandibular tori
Frenectomy
Transseptal fiberotomy
Excision of hyperplastic tissue
Surgical exposure of impacted or unerupted tooth
Vestibuloplasty
Removal of dental cysts and tumors

Anesthesia

General anesthesia
IV sedation

General anesthesia or IV sedation is payable for the following covered services when performed in the dental office. Benefits for anesthesia is limited to one hour unless complexity of service warrants extended time.

Removal of impacted teeth, removal of dental cysts and tumors, multiple restorative services for Dependent Children under the age of five, periodontal osseous surgery, bone grafting, surgical removal of four third molars on the same date of service.

Other Services

Emergency Examination (evaluation)

Emergency Exam

Covered once in any six consecutive month period.

Consultation with specialist

Covered once in any 12 consecutive month period. Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Antibiotic drug injection

Office visit after regularly scheduled hours

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Palliative treatment

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Recementing

Inlay
Onlay
Crown
Bridgework

Covered only if done more than 12 months after initial insertion of inlay, onlay, crown, or bridge, and than not more than one time in any 24 consecutive month period.

Repairs to complete or partial denture, bridge, or crown

Covered only if repair is done more than 12 months after initial insertion of the denture, bridge, or crown, and then not more than one time in any 24 consecutive month period.

Relining or rebasing complete or partial dentures

Covered only if relining or rebasing is done more than 12 months after initial insertion of the denture and then not more than one time in any 24 consecutive month period.

Tissue Conditioning

Covered only if at least 12 months have elapsed since the insertion of a complete or partial denture and not more than once in any 24 consecutive month period.

Denture Adjustment

Covered once in any 12 consecutive month period and only if at least 12 months have elapsed since the insertion of the denture.

Section B (4) - Dental Expense Insurance - Schedule of Dental Procedures - Unit 3

Article 1 - Schedule of Dental Procedures

Unless The Principal agrees otherwise, Covered Charges will include only charges for procedures listed in this PART IV, Section B (4). If a non-listed procedure is accepted, The Principal will determine its maximum allowance based on the Prevailing Charges for a listed procedure of comparable nature.

Article 2 - Dental Care Unit 3 - Major Procedures

Covered Charges will be the actual cost charged to the Member or Dependent for Treatment or Service for the listed procedures described in this article but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Dental Procedure

Restorations

Inlays and onlays

Inlay or onlay restorations are covered only if the tooth cannot be restored by a filling and (for replacements) at least 60 consecutive months have elapsed since the last placement.

For persons under 16 years of age, the benefit for inlay is limited to amalgam or resin filling.

For persons under 16 years of age, the benefit for onlay is limited to resin or stainless steel crowns.

The date the inlay or onlay is cemented in the mouth will be used in determining benefits payable.

Crowns (single restorations only)

Resin (laboratory)
Resin with nonprecious metal
Resin with semiprecious metal
Resin with gold
Porcelain
Porcelain with nonprecious metal
Porcelain with semiprecious metal
Porcelain with gold

Porcelain (3/4 posterior cast)
Gold (3/4 posterior cast)
Gold (full cast)
Nonprecious metal (full cast)
Semiprecious metal (full cast)

Crowns are covered only if the tooth cannot be restored by a filling and (for replacements) at least 60 consecutive months have elapsed since the last placement. Crowns for the primary purpose of splinting, altering, or maintaining vertical dimension, or restoring occlusion are not covered. Crowns for the replacement of inlay or onlay or bridge abutment are covered only if at least 60 consecutive months have elapsed since the last placement of the restoration. Crowning of implant replacing a tooth missing prior to the effective date is not covered. For persons under 16 years of age, the benefit for crowns on vital teeth is limited to prefabricated resin or stainless steel crowns. Crowning of implant replacing a pontic will not be covered unless at least 60 consecutive months has elapsed since placement of the pontic. The date the crown is cemented in the mouth will be used in determining benefits payable.

Cast post and core

Covered only for teeth that have had root canal therapy. Covered once per tooth per 60 consecutive months. There will be no separate benefit payable for cast post and core if restorative procedure is not covered under this plan.

Core Buildup

Covered only when required for retention and preservation of the tooth. There will be no separate benefit payable for core buildup if restorative procedure is not covered under this plan.

Covered once per tooth per 60 consecutive month period.

Prosthodontics, Fixed

Fixed bridges - initial placement or replacement

Coverage for bridges limited to persons over age 16.

Initial placement of fixed bridges to replace teeth which were missing prior to the effective date of the insured person's coverage will not be covered unless it includes the replacement of a Functioning Natural Tooth extracted while the person is insured under this Group Policy (provided that tooth was not an abutment to an existing partial denture that is less than 60 months old). In that event, benefits are payable only for the replacement of those teeth which were extracted while insured under this Group Policy.

Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than 60 consecutive months old and is not serviceable and cannot be repaired.

The date bridgework is cemented in the mouth will be used in determining benefits payable.

Prosthodontics, Removable

Complete or partial dentures - initial placement or replacement

Initial placement of complete or partial dentures to replace teeth which were missing prior to the effective date of the insured person's coverage will not be covered unless it includes the replacement of a Functioning Natural Tooth extracted while insured under this Group Policy. In that event, benefits are payable only for the replacement of those teeth which were extracted while insured under this Group Policy.

Benefits for the replacement of an existing complete or partial denture are payable only if the existing denture is more than 60 consecutive months old and is not serviceable and cannot be repaired.

Covered Charges for complete or partial dentures do not include any additional charges for over-dentures or for precision or semi-precision attachments.

Dental Implants

Surgical placement of implant body (endosteal, eposteal, or transosteal implant)
Implant connecting bars and supporting structures
Implant repair and removal
Implant maintenance procedure (twice per year)

Coverage for dental implants is limited to persons over the age of 16.

Initial placement of dental implants and/or supporting structures to support the replacement of teeth which were missing prior to the effective date of the Member's or Dependent's coverage will not be covered.

Benefits for the replacement of an existing implant are payable only if the existing implant is no longer serviceable and 60 consecutive months have elapsed since the last placement of the implant. Implants to replace existing fixed bridgework, partial or full denture will not be covered unless 60 consecutive months have elapsed since the last placement of fixed bridgework, partial or full denture.

Section B (5) - Dental Expense Insurance - Schedule of Dental Procedures - Unit 4

Article 1 - Schedule of Dental Procedures

Unless The Principal agrees otherwise, Covered Charges will include only charges for procedures listed in this PART IV, Section B (5). If a non-listed procedure is accepted, The Principal will determine its maximum allowance based on the Prevailing Charges for a listed procedure of comparable nature.

Article 2 - Dental Care Unit 4 - Orthodontia for children only who are less than 19 years of age when appliance or bands are initially placed.

Covered Charges will be the actual cost charged to the Member or Dependent for Treatment or Service for the listed procedures described in this article but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Dental Procedure

Orthodontic Services

Formal, full-banded retention and treatment, including x-rays and other diagnostic procedures.

Removable or fixed appliances for tooth or bony structure guidance or retention.

Section C - Claim Procedures

Article 1 - Notice of Claim

Written notice must be sent to The Principal by or for a Member or Dependent who wishes to file claim for benefits under this Group Policy. This notice must be sent within 20 calendar days after the date of loss. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Article 2 - Claim Forms

The Principal, when it receives notice of claim, will provide appropriate claim forms for filing proof of loss. If the forms are not provided within 15 calendar days after The Principal receives notice of claim, the person will be considered to have complied with the requirements of the Group Policy regarding proof of loss upon submitting, within the time specified below for filing proof of loss, Written proof covering the occurrence, character, and extent of the loss.

Article 3 - Proof of Loss

Written proof of loss must be sent to The Principal within 12 months after the date of the loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when The Principal receives proof of loss. Proof of loss includes the patient's name, Member's name (if different from the patient's name), provider of services, dates of service, diagnosis, description of Treatment or Service provided and the extent of the loss. The Principal may request additional information to substantiate loss or require a Signed unaltered authorization to obtain that information from the provider. Failure to comply with The Principal's request could result in declination of the claim. The Principal may also require x-rays, dental charts, and other evidence needed to determine the dental condition treated and the services provided.

Article 4 - Payment, Denial, and Review

The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, The Principal will send a Written explanation prior to the expiration of the 30 calendar days. If The Principal does not deny the claim and requests additional information to complete the review, the claimant is then allowed up to 45 calendar days to provide all additional information requested. The Principal will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

Unless otherwise preempted by the Employee Retirement Income Security Act (ERISA), state time limits will apply. State law requires that benefits payable under this Group Policy will be payable not more than 30 days after receipt of proof and subject to the proof of loss.

In actual practice, benefits under this Group Policy may be payable sooner, provided The Principal receives complete and proper proof of loss. If a claim is not payable or cannot be processed, The Principal will submit a detailed explanation of the basis for its denial. The explanation will include:

a. the specific reason(s) for the adverse benefit determination;

b. reference to the specific plan provision(s) on which the determination is based;

c. a description of any additional material or information necessary for the claimant to complete the claim;

d. a description of the review procedures of The Principal including time limits applicable to such procedures and the claimant's right to civil action following an adverse benefit on review;

e. if an internal rule, guideline, protocol, other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and

f. if the adverse benefit determination is based on a dental necessity or experimental treatment or similar exclusion, either an explanation of the scientific or clinical judgment for the determination or a statement that an explanation will be provided free of charge upon request.

A claimant may request an appeal of a claim denial by Written request to The Principal within 180 calendar days of receipt of the notice of denial. The Principal will make a full and fair review of the claim. The Principal may require additional information to make the review. The Principal will notify the claimant in Writing of the appeal decision within 60 calendar days of receiving the appeal request. The appeal review must be completed before filing a civil action or pursuing any other legal remedies. The notification will include:

a. the specific reason or reasons for the adverse benefit determination;

b. reference to the specific plan provision(s) on which the determination is based;

c. upon request and free of charge, the claimant is entitled to receive reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim for benefits;

d. if an internal rule, guideline, protocol, other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

e. if the adverse benefit determination is based on a dental necessity or experimental treatment or similar exclusion, either an explanation of the scientific or clinical judgment for the determination or a statement that an explanation will be provided free of charge upon request; and

f. the claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office and the State insurance regulatory agency.

For purposes of this section, "claimant" means Member or Dependent.

Article 5 - Dental Treatment Plan

The Principal encourages the use of predeterminations to determine the extent of coverage for a proposed course of treatment. A Dental Treatment Plan may be filed with The Principal before treatment begins. Upon receipt, The Principal will provide a Written response indicating the benefits that may be payable for the proposed treatment. The Principal suggests predetermination of benefits for the following non-emergency types of treatments: inlays, onlays, single crowns, prosthetics, periodontics and oral surgery.

The filing of a Dental Treatment Plan is intended to help avoid any misunderstanding between the Dentist, the insured, and The Principal as to how much will be paid for dental work. A Dental Treatment Plan is not a guarantee of what The Principal will pay. It informs the insured person and the Dentist, in advance, what The Principal will pay for a covered dental service named in the Dental Treatment Plan. If The Principal does not agree with a Dental Treatment Plan, The Principal has the right to base payments on treatment suited to the covered person's condition by accepted standards of dental practice.

Article 6 - Facility of Payment

Benefits under this Group Policy for other than orthodontia will be payable immediately after The Principal receives complete and proper proof of loss. Benefits for orthodontia will be payable as described in Article 7 below.

The Principal will normally pay all benefits to the Member. However, if the claimed benefits are for dental care provided for a Dependent, The Principal may make payment to the Dependent. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge The Principal to the full extent of those payments.

a. If payment amounts remain due upon a Member's death, those amounts may, at The Principal's option, be paid to the Member's estate, spouse, child, parent, or provider of dental services.

b. If The Principal believes a person is not legally able to give a valid receipt for a benefit payment and no guardian has been appointed, The Principal may pay whoever has assumed the care and support of the person.

c. Benefits payable to a PPO Provider will be paid directly to the PPO Provider on behalf of the Member or Dependent.

Note: When benefits under this Group Policy are payable for Treatment or Services received from a foreign provider, the claim must be filed in English and requested in American currency amounts. Such claims will be payable for Covered Charges for Treatment or Services but only to the extent that the actual cost charged does not exceed Prevailing Charges. Benefits will be paid directly to the Member. No assignments will be made to foreign providers.

Article 7 - Payment of Orthodontia Benefits

Benefits under this Group Policy for comprehensive orthodontia treatment will be payable in installments:

a. immediately upon receipt of proof that the initial treatment (including setting of the appliance or bands) has been completed; and

b. at the end of each following calendar month upon receipt of proof that the Period of Dental Treatment has continued.

The Covered Charge for the initial treatment will be 25% of the lesser of:

a. the Dental Care Unit 4 lifetime maximum; or

b. Covered Charges as outlined in PART IV, Section B (5), Article 2 multiplied by the coinsurance shown in PART IV, Section B (1), Article 1.

The monthly Covered Charge will be determined by averaging the remaining Covered Charge over the estimated time required to complete the Orthodontic Treatment or Service.

Treatment or Service for other than comprehensive orthodontia treatment may be paid in one lump sum.

The Dental Care Unit 4 Maximum Payment Limit under this Group Policy will be reduced by any orthodontia benefits paid under the Prior Plan.

For the purpose of this section, "Prior Plan" will mean the Member's group dental expense coverage for which this Group Policy is a replacement.

Orthodontia Treatment or Service will not be covered if the appliance or bands were placed prior to being insured under this Group Policy, unless:

a. the Dependent Child is currently in a treatment plan which was covered under the Prior Plan; and

b. there has been no Lapse in Coverage; and

c. the Member or Dependent submits proof that:

    (1) the Dental Care Unit 4 Maximum Payment Limit under this Group Policy was not exceeded under the Prior Plan; and
    (2) the orthodontic treatment was started and bands or appliances were inserted while insured under the Prior Plan; and
    (3) orthodontic treatment has been continued while the Member or Dependent is insured under this Group Policy.

Article 8 - Recoding of Procedures

When a claim contains one or more procedure codes with the same date of service, The Principal may review the claim to determine whether it contains, among other things, coding irregularities (including duplicative or combined codes), coding conflicts or coding errors. The Principal will base such review on generally recognized and authoritative coding resources, including but not limited to: Current Dental Terminology (CDT).

If The Principal determines, in its own discretion, that the claim may be more appropriately coded using the same or different codes, the claim will be recoded and processed accordingly to determine the allowable amount and extent of benefits.

Article 9 - Dental Examinations

The Principal may have the person whose loss is the basis for claim examined by a Dentist. The Principal will pay for these examinations and will choose the Dentist to perform them.

Article 10 - Legal Action

Legal action to recover benefits under this Group Policy may not be started earlier than 60 calendar days after required proof of loss has been filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after that proof is required to be filed.

Article 11 - Time Limits

Any time limit listed in this section will be adjusted as required by law.

Section D - Coordination with Other Benefits

Article 1 - Purpose

The intent of this section is to provide that the sum of benefits paid under this Group Policy plus benefits paid under all other Plans will not exceed the lesser of the financial liability of the Member or Dependent or the Prevailing Charge of The Principal for a Treatment or Service.

Article 2 - Definitions

As used in this section, the terms listed below will mean:

a. Plan

Any dental expense benefits provided under:

(1) any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or association; and
(2) any program required or established by state or Federal law (including Medicare Parts A and B); and
(3) any program sponsored by or arranged through a school or other educational agency; and
(4) the first-party medical expense provisions of any automobile policy issued under a no-fault insurance statute and traditional fault-type contracts.

The term Plan will not include benefits provided under a student accident policy, nor will the term Plan include benefits provided under a state medical assistance program where eligibility is based on financial need.

Also, the term Plan will apply separately to those parts of any program that contain provisions for coordination of benefits with other Plans and separately to those parts of any program which do not contain such provisions.

b. Primary Plan/Secondary Plan

The order of benefit determination rules determine whether This Plan is a "Primary Plan" or a "Secondary Plan" when compared to another Plan covering the person.

When this Plan is Primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is Secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

c. Allowable Expense

A dental care service or expense, including Deductibles, coinsurance, and Copayments, if any, that is covered at least in part by any of the Plans covering the person for whom benefits are claimed. When a Plan provides benefits in the form of services (for example a DHMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

(1) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.
(2) The amount a benefit is reduced by the Primary Plan because a covered person does not comply with the Plan provisions. Example of this provision is preferred provider arrangements.

d. Claim Determination Period

The part of a Calendar Year during which a Member or Dependent would receive benefit payments under this Group Policy if this section were not in force.

Article 3 - Effect on Benefits

Benefits otherwise payable under this Group Policy for Allowable Expenses during a Claim Determination Period may be reduced if:

a. benefits are payable under any other Plan for the same Allowable Expenses; and

b. the rules listed in Article 4 below provide that benefits payable under the other Plan are to be determined before the benefits payable under this Group Policy.

The reduction will be the amount needed to provide that the sum of payments under this Group Policy plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses. Each benefit that would be payable in the absence of this section will be reduced proportionately. Any such reduced amount will be charged against any applicable benefit limit of this Plan.

For this purpose, benefits payable under other Plans will include the benefits that would have been paid had claim been made for them. Also, for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B whether or not the person is covered under that Part B.

Article 4 - Order of Benefit Determination

Except as described in Article 5 below, the benefits payable of a Plan that does not have a coordination of benefits provision substantially similar to the provision described in this section will be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination will be:

a. Nondependent/Dependent. The benefits of a Plan which covers the person for whom benefits are claimed as an employee, Member, or subscriber (that is, other than as a Dependent) are determined before the benefits of a Plan which covers the person as a Dependent. Exception: If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(1) secondary to the Plan covering the person as a Dependent; and
(2) primary to the Plan covering the person as other than a Dependent (e.g., a retired employee);

then the benefits of the Plan covering the person as a Dependent are determined before those of the Plan covering that person as other than a Dependent.

b. Dependent Child--Parents Not Separated or Divorced. Except as stated in paragraph c. below, when this Group Policy and another Plan cover the same child as a Dependent of different persons called "parents," the benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if another Plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. Dependent Child--Separated or Divorced Parents. If two or more Plans cover a Dependent Child of divorced or separated parents, benefits for the child are determined in this order:

(1) first, the Plan of the parent with custody of the child;

(2) then, the Plan of the spouse of the parent with custody of the child; and
(3) finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules for Dependent Children of parents who are not separated or divorced.

e. Active/Inactive Employee. The benefits of a Plan which covers the person for whom benefits are claimed as an employee who is neither laid off nor retired, or as that employee's Dependent, are determined before the benefits of a Plan which covers that person as a laid-off or retired employee or as that employee's Dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

f. Continuation of Coverage. If a person for whom coverage is provided under a right of continuation according to Federal or state law is also covered under another Plan, the following will be the order of benefit determination:

(1) first, the benefits of a Plan covering the person as an employee, Member or subscriber (or as that person's Dependent);
(2) second, the benefits under the continuation coverage.

If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

g. Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the benefits of the Plan which covered the person for whom benefits are claimed longer are determined before those of the Plan which covered that person for the shorter time.

Article 5 - Medicare Exception

Unless otherwise required by Federal law, benefits payable under Medicare will be determined before the benefits payable under this Group Policy.

Article 6 - Exchange of Information

Any person who claims benefits under this Group Policy must, upon request, provide all information The Principal believes is needed to coordinate benefits as described in this section.

In addition, all information The Principal believes is needed to coordinate benefits may be exchanged with other companies, organizations, or persons.

Article 7 - Facility of Payment

The Principal may reimburse any other Plan if:

a. benefits were paid by that other Plan; but

b. should have been paid under this Group Policy in accordance with this section.

In such instances, the reimbursement amounts will be considered benefits paid under this Group Policy and, to the extent of those amounts, will discharge The Principal from liability.

Article 8 - Right of Recovery

If, in accordance with this section, it is determined that benefits paid under this Group Policy should have been paid by any other Plan, The Principal will have the right to recover those payments from:

a. the person to or for whom the benefits were paid; and/or

b. the other companies or organizations liable for the benefit payments.

POLICY ENDORSEMENT - VERMONT
MANDATORY CIVIL UNION ENDORSEMENT

PURPOSE:

Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons. This Endorsement is a part of and amends the Group Policy, contract, or certificate to comply with Vermont law.

DEFINITIONS, TERMS, CONDITIONS, AND PROVISIONS:

The definitions, terms, conditions, and any other provisions of the Group Policy, contract, certificate, and/or riders and endorsements to which this mandatory Endorsement is attached are hereby amended and superseded as follows:

Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage," "spouse," "husband," "wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family," and any other such terms include the relationship created by a civil union established according to Vermont law.

Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage," divorce decree," "termination of marriage," and any other such terms include the inception or dissolution of a civil union established according to Vermont law.

"Dependent" means a spouse, a party to a civil union established according to Vermont law, and a child or children (natural, stepchild, legally adopted, or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

"Child or covered child" means a child (natural, stepchild, legally adopted, or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

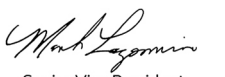
CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE

Vermont law grants parties to a civil union the same benefits, protections, and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections, and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Income Retirement Security Act of 1974 known as "ERISA," controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a

civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons.

Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under this Group Policy, contract, certificate, rider, or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

PRINCIPAL LIFE INSURANCE COMPANY



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