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

Group Policyholder

Gunnison Valley Hospital

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

The first premium for this Policy is due on its effective date. Subsequent premiums are due on February 1, 2017, and on the same day of each month after that. Policy anniversaries will be each January 1st; unless shown otherwise on the Premium Rate Schedule inside.

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

The Lincoln National Life Insurance Company has executed this Policy at its Group Insurance Service Office in Omaha, Nebraska. The issue date of the Policy is January 1, 2017.

Chals A. Bradley Dennis R Glass

SECRETARY PRESIDENT

GROUP DENTAL INSURANCE POLICY
No. 00001D033225

TABLE OF CONTENTS

TABLE OF CONTENTS
(Continued)

Gunnison Valley Hospital
00001D033225
SCHEDULE OF BENEFITS

ELIGIBLE CLASS

Class 1 All Full-Time and Regular Part-Time Employees

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

Use of a Participating Dentist is voluntary. The Covered Person may receive treatment from any Dentist he or she chooses. And he or she is free to change Dentists at any time. But, the Covered Employee's out-of-pocket expenses for covered services are usually lower when the services are provided by a Participating Dentist.

A Directory of Participating Dentists is available from the Group Policyholder. Information about Participating Dentists may also be obtained by:
(1) accessing the Company's web site at **www.LFG.com**; or
(2) calling the Company's Client Services Department **(800) 423-2765**.

This information is included on the ID card provided to each Covered Employee. When the Covered Employee enrolls Eligible Dependents, two ID cards will be provided.

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

Gunnison Valley Hospital
00001D033225
SCHEDULE OF BENEFITS
For
Class 1 - All Full-Time and Regular Part-Time Employees

FULL-TIME MINIMUM HOURS: 30 hours per week
PART-TIME MINIMUM HOURS: 20 hours per week

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

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

Benefit Waiting Period:

Type 2 Procedures:	None
Type 3 Procedures:	None
Type 4 Procedures:	12 Months

Prior Plan Credits: Terms of the Prior Plan Credit provision apply for persons covered on the issue date of this Policy. Refer to the Prior Plan Credit provision in this Policy.

Late Entrant Limitation (when applicable):

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

Gunnison Valley Hospital
00001D033225
SCHEDULE OF BENEFITS
(Continued)
For
Class 1

DENTAL BENEFITS

	PPO PLAN In-Network Services	PPO PLAN Out-of-Network Services
CALENDAR YEAR DEDUCTIBLE		
for these Procedure Types (combined)	Types 2 & 3	Types 2 & 3
INDIVIDUAL	$100	$100
FAMILY	$200	$200
PERCENT PAYABLE		
Type 1 - Diagnostic & Preventive Services	100%	100%
Type 2 - Basic Services	100%	100%
Type 3 - Major Services	50%	50%
Type 4 - Orthodontic Services for Dependent Children	50%	50%
Type 1, 2 and 3 Benefits Based On	Negotiated Fees	90th Percentile of Usual & Customary Allowance
CALENDAR YEAR MAXIMUM for these Procedure Types (combined)	$1,200 Types 1, 2 & 3	$1,200 Types 1, 2 & 3
LIFETIME MAXIMUM for Type 4 Procedures – Orthodontics for Dependent Children	$1,000	$1,000

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

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

DEFINITIONS

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

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

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

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

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

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

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

BENEFIT WAITING PERIOD means the period of time a Covered Person must be covered for Dental Expense Benefits -- or for a specific type of Dental Expense Benefits -- under this Policy before that type of service becomes eligible for coverage. (The Benefit Waiting Period shall not apply to a covered newborn child).

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

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

COVERAGE MONTH means that period of time:

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

at the Group Policyholder's primary place of business.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The leave period, may:
(1) consist of consecutive or intermittent work days; or
(2) be granted on a part-time equivalency basis.

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

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

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

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

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

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

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

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

In order to qualify for this exception, each person applying for coverage under the Group Policyholder's dental plan must:

(1) provide proof of coverage under the spouse's prior dental plan; and
(2) enroll for coverage and pay premiums for the Group Policyholder's plan within 31 days following loss of coverage under the other dental plan.

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

MILITARY LEAVE means a leave of absence that:

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

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

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

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

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

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

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

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

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

PARTICIPATING DENTIST means a Dentist who:
(1) has signed a contract with the dental network being made available through this Policy; and
(2) has agreed to abide by the rules of that network.

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

PAYROLL PERIOD means that period of time established by the Group Policyholder for payment of employee wages. A Payroll Period may be weekly, biweekly, semimonthly or monthly.

POLICY means this group dental policy issued by the Company to the Group Policyholder.

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

REGULAR PART-TIME EMPLOYEE means an employee of the Group Policyholder or Participating Employer who is:
(1) regularly scheduled to work at least the number of hours shown in the Schedule of Benefits;
(2) a member of a class which is eligible for coverage under this Policy;
(3) not a temporary or seasonal employee; and
(4) a citizen of the United States or legally working in the United States.

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

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

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

GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PROVISIONS APPLICABLE TO PARTICIPATING EMPLOYERS

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

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

The Senior Care Center

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

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

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

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

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

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

(1) 75% of eligible employees; or
(2) 10 enrolled employees.

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

ELIGIBILITY AND EFFECTIVE DATES FOR EMPLOYEE DENTAL COVERAGE

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

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

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

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

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

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

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

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

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

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

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

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

TERMINATION OF EMPLOYEE DENTAL COVERAGE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

subject to payment of premiums.

TERMINATION OF EMPLOYMENT. If the Covered Employee's employment ends, coverage may be continued until the earlier of:

(1) 18 months after the Covered Employee's employment ends;

(2) the date the Covered Employee becomes eligible for Medicare or Medicaid, or for other group dental coverage; or
(3) the date coverage would otherwise end;

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

When coverage can be continued both under the above paragraph or federal COBRA law, continuation will be allowed under the more favorable continuation provision; but in no event will continuation periods be allowed to run consecutively.

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

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

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

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

ELIGIBILITY FOR DEPENDENT DENTAL COVERAGE

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

(1) legal spouse, who is not legally separated from the Covered Employee;
(2) unmarried child less than 26 years of age; or
(3) unmarried child age 26 years or older, who is:
    (a) continuously unable to earn a living because of a physical or mental disability; and
    (b) chiefly dependent upon the Covered Employee for support and maintenance.

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

"Child" includes:

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

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

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

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

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

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

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

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

EFFECTIVE DATES FOR DEPENDENT DENTAL COVERAGE

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

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

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

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

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

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

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

(1) the Employee completes a written application; and

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

within 31 days of the date the Dependent is acquired.

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

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

TERMINATION OF DEPENDENT DENTAL COVERAGE

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

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

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

CONTINUATION OF DEPENDENT DENTAL COVERAGE. If Dependent Dental Coverage would otherwise terminate due to the Covered Employee's termination of employment, death, or change in marital status, Dependent Dental Coverage may be continued until the earlier of:

(1) 18 months after the date of termination of employment, death or change in marital status;
(2) the last day of the period of coverage for which premium has been paid on behalf of the Covered Employee's Dependents, if any premium is not paid when due;
(3) the date the Dependent becomes insured under another group dental plan;
(4) the date the Dependent becomes eligible for Medicare or Medicaid; or
(5) the date this Policy terminates.

When coverage can be continued under the above paragraph or federal COBRA law, continuation will be allowed under the more favorable continuation provision; but in no event will continuation periods be allowed to run consecutively.

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

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

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

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

PREMIUMS AND PREMIUM RATES

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

GRACE PERIOD. A grace period of 31 days from the due date will be allowed for the payment of each premium after the first. This Policy will remain in effect during the grace period, unless the Group Policyholder gives the Company advance written notice of termination. The Group Policyholder will remain liable for payment of a pro rata premium for the time this Policy remained in force during the grace period.

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

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

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

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

(1) each rate shown in the Premium Rate Schedule; by
(2) the number of employee and family units covered;

and then adding the monthly billing fee, if any.

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

PREMIUM RATE SCHEDULE

Monthly Dental Rates

Employee Only Coverage	$38.00 per employee
Employee and Spouse Coverage	$80.40 per family unit
Employee and Children Coverage	$98.00 per family unit
Employee, Spouse & Children Coverage	$144.41 per family unit

The above rate or rates are guaranteed until January 1, 2018, unless any of the Policy's terms or the Company's liability are changed, as described in parts 1 through 6 of the PREMIUM RATE CHANGE section, above.

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

NOTICE TO THE COMPANY WHEN A COVERED PERSON'S DENTAL COVERAGE TERMINATES. The Group Policyholder is responsible for the payment of premium for each Covered Person through the earlier of:

(1) the date that the Company is notified by the Group Policyholder that the Covered Person's Dental Coverage has terminated or that the Covered Person is no longer eligible; except, if a Covered Dependent becomes enrolled in the Children's Basic Health Plan, established pursuant to article 8 of title 25.5, C.R.S., the Group Policyholder shall notify the Company of the change in coverage at least 30 days prior to the date that the Dependent is no longer covered; or

(2) the date the Group Policyholder submits notice according to the **TERMINATION BY GROUP POLICYHOLDER** provision found in the **POLICY TERMINATION**.

POLICY TERMINATION

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

(1) the number of Covered Employees is less than ten;
(2) part of the premium is paid by Covered Employees or through a Section 125 plan; and for Employee Dental Coverage, less than 44% of the eligible Employees are covered (or less than 60% of eligible employees with dependents are insured for any dependent dental coverage);
(3) all of the premium is paid from the Group Policyholder's general funds:
    (a) for Employee coverage; and less than 100% of eligible Employees are covered by the Policy; or
    (b) for Employee and Dependent Coverage; and less than 100% of eligible Employees and Dependents are covered by this Policy;
(4) the Group Policyholder, without good cause, fails to:
    (a) promptly furnish any information which the Company may reasonably require;
    (b) perform its duties pertaining to this Policy in good faith;
(5) the Company terminates all other policies where permitted by their terms which provide dental benefits in the same state in which this Policy was issued; or
(6) state law otherwise requires this Policy to be terminated.

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

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

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

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

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

AUTOMATIC TERMINATION. If any premium remains unpaid at the end of the Grace Period; then this Policy will automatically terminate, without any action on the Company's part, on the last day of the Grace Period. The Group Policyholder remains responsible for the payment of premiums to the date of termination.

DENTAL EXPENSE BENEFITS

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

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

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

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

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

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

BENEFIT WAITING PERIODS. The Benefit Waiting Periods are shown on the Schedule of Benefits pages of this Policy. (The Benefit Waiting Period shall not apply to a covered newborn child.)

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

ALTERNATIVE PROCEDURES

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

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

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

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

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

DENTAL EXPENSE BENEFITS
ORTHODONTICS FOR CHILDREN

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

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

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

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

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

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

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

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

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

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

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

LIMITATIONS AND EXCLUSIONS

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

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

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

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

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

(5) Orthodontic (Type 4) services:
  (a) which begin before the Dependent child becomes covered under this Policy for orthodontic services, subject to the Prior Plan Credit provision, if included in this Policy;
  (b) which begin during a Benefit Waiting Period or a Late Entrant Limitation Period, subject to the Prior Plan Credit provision, if included in this Policy;
  (c) received after the Dependent child's coverage ends, due to attainment of the maximum age, or for any other reason; or
  (d) received after coverage for Type 4 services is terminated under this Policy.

(6) any treatment or services which:
  (a) are for mainly cosmetic purposes (including but not limited to bleaching of teeth; veneers; and porcelain, composite, or resin-based restorations or prosthetics for posterior teeth, except as specifically shown in the List of Covered Dental Procedures included in this Policy); or
  (b) are related to the repair or replacement of any prior cosmetic procedure.

(7) services related to the replacement of third molars (wisdom teeth).

(8) bone grafts or any regenerative procedure in an extraction site.

(9) except as specifically shown in the List of Covered Dental Procedures included in this Policy, any procedure associated with the placement, restoration, or removal of a dental implant, and any related expenses. Related expenses may include but are not limited to:
   (a) periodontal services which would not have been performed if the implant had not been planned and/or installed; and
   (b) any resulting increase in charges for services covered by this Policy that are related to the dental implant.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COORDINATION OF DENTAL EXPENSE BENEFITS

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

(1) **Primary Benefits.** When this Plan must pay its full benefits first, the Dental Expense Benefits under this Policy will be paid as if the other coverage did not exist.

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

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

BENEFIT SAVINGS. The amount by which this Plan's benefits have been reduced due to such coordination will accrue during the Claim Period. This amount will be used to pay any Allowable Expenses which:
(1) are incurred by that Claimant during the same Claim Period; and
(2) are not otherwise paid by any Plan.

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

"**Plan**" means any group insurance or group type coverages (whether insured or uninsured), which provide medical or dental care benefits or services. This includes but is not limited to:
(1) Blue Cross and Blue Shield plans;
(2) blanket (other than school accident coverage) and franchise insurance plans;
(3) Health Maintenance Organization (HMO) and Dental Maintenance Organization (DMO) plans; and
(4) other prepayment, group practice and individual practice plans.

It includes any coverage under a government medical or dental plan required or provided by law; except Medicaid. This Plan must pay its benefits before Medicaid pays. Coordination with Medicare will be in accord with federal law. It also includes individual or group private passenger automobile personal injury coverage under Colorado's "No Fault" Motor Vehicle insurance.

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

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

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

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

ORDER OF BENEFIT DETERMINATION RULES. To decide which Plan pays first, the Company will use the first of the following rules which applies.

(1) **Noncoordinated/Coordinated Plan.** A Plan without a coordination provision will pay its benefits before a Plan which includes a coordination provision.

(2) **Nondependent/Dependent.** A Plan covering the Claimant as an employee, member or subscriber will pay its benefits before a Plan covering the Claimant as a dependent.

(3) **Child of Parents Not Separated or Divorced.** If the Claimant is a dependent child whose parents **are not** separated or divorced, the Plan of the parent whose birthday falls earlier in the calendar year will pay first. However:
   (a) if both parents have the same birthday, the Plan which has covered the parent longer will pay first; and
   (b) if the Plan coordinates benefits based upon the sex of the parents, the male parent's plan will pay first.

(4) **Child of Separated or Divorced Parents.** If the Claimant is a dependent child whose parents **are** separated or divorced, then:
   (a) the Plan of the parent who is required by court decree to pay the child's dental expenses will pay first;
   (b) provided the Plan receives notice of the court decree before paying or providing benefits.

   If there is no notice of a court decree requiring payment of such expense, then:
   (a) the custodial parent's Plan pays first;
   (b) the Plan of the custodial parent's spouse pays next (if the custodial parent is remarried); and
   (c) the noncustodial parent's Plan pays last.

   When a noncustodial parent is responsible for the Claimant's dental expenses, benefits may be paid directly to the provider, if the custodial parent requests this.

(5) **Active/Inactive Employee.** A Plan covering the Claimant as a laid off or retired employee (or a dependent of such an employee) will pay after a Plan covering the Claimant on some other basis; provided the other Plan:
   (a) includes this coordination rule for laid off or retired employees; or
   (b) is issued in a state which requires this rule by law.

   A Plan covering the Claimant pursuant to federal COBRA Continuation law will pay after a Plan covering the Claimant as an employee (or a dependent of an employee).

(6) **Length of Coverage.** If none of the above rules apply, then the Plan which has covered the Claimant longer will pay first.

RIGHT TO EXCHANGE DATA. To determine the benefits payable under this section, the Company has the right to exchange information with any insurance company, organization or person. Such data may be exchanged without the consent of (or any notice to) the Covered Person. A Covered Person who claims benefits under this Policy must provide the Company with the data required to apply this Section.

PAYMENT AND OVERPAYMENT. Other Plans may make payments which this Plan should have made in accord with this Section. In that event, the Company has the right to reimburse any amount it deems necessary to satisfy the intent of this Section. If the Company pays such benefits to an organization in good faith, it will not be liable to the extent of the payment.

The Company also has the right to recover any overpayment it makes because of coverage under another Plan. The Company may recover the amounts needed to satisfy the intent of this Section from any insurance company, organization or person to or for whom Policy benefits were paid.

CLAIM PROCEDURES FOR DENTAL COVERAGE

NOTICE AND PROOF OF CLAIM

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

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

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

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

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

Within 15 days after receiving the first proof of claim, the Company may send a written acknowledgment. Within 30 calendar days after receiving the first proof of claim, it will request any missing information or additional items needed to support the claim. This may include:

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

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

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

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

PHYSICAL EXAMS. While a dental claim is pending, the Company may have the claimant examined:

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

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

TIME OF PAYMENT OF CLAIMS. Any Dental Expense Benefits payable under this Policy will be paid immediately after the Company receives complete proof of claim and confirms liability. Clean Claims will be paid within 30 calendar days after receipt by electronic submission, or within 45 calendar days after receipt by other means. **"Clean Claim"** means a claim for dental care expenses that is submitted to the Company on a standard claim form with all required fields completed with correct and complete information, including all required documents. **"Clean Claim"** does not include a claim for expenses incurred during a period of time for which premiums are delinquent, except to the extent required by law.

TO WHOM PAYABLE. Dental Expense Benefits will be paid to the Covered Employee; unless:

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

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

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

This notice will be sent within 15 days after the Company resolves the claim. It will be sent within 30 days after the Company receives the first proof of claim, if reasonably possible.

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

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

The notice will explain:

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

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

Exception--Incomplete Claim. If the Company needs more information from the claimant to process a claim that does **not** involve Utilization Review; then it must be supplied within 30 calendar days after the Company requests it. The resulting delay will not count towards the above time limit for claim processing.

Interest Penalty. If the Company fails to pay, deny or settle a claim in accordance with the above provisions within 90 days after receiving the claim, it shall be liable for the covered benefit plus interest at the rate of 10% annually on the total amount accruing from the date the payment was due.

Exception--Utilization Review. "Utilization Review" means a review of the medical necessity, appropriateness or efficiency of dental services that would otherwise be covered under this Policy. It also includes review of dental necessity to determine if Policy exclusions apply in a given situation. In accord with Colorado law, **s**pecial time limits will apply when the claim requires a Utilization Review. In that case, the Company must:

(1) resolve the claim within 30 working days after receiving complete proof of claim; and
(2) send the notice of its claim decision within five working days of resolving the claim.

If more information is needed to complete the Utilization Review; then the Company must:

(1) request it within two working days after receiving the first proof of claim;
(2) allow the claimant 20 calendar days to furnish the requested information; and then
(3) complete the utilization review based upon the information it has, within 30 working days after the requested information is due or received (whichever is earlier).

The Company must send the claimant and the dentist written notice of its claim decision, within five working days after resolving the claim.

COMPANY'S INTERNAL REVIEW PROCESS. Within 180 days after receiving a denial notice, the Covered Employee may request a first level review by sending the Company:

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

The claimant may review certain non-privileged information relating to the request for review. If the 180 day deadline for filing the request for claim review ends on a weekday or holiday, the deadline will be extended to the next business day. The Company will review the claim and send the Covered Employee a written notice of its decision. The notice will be sent within 30 days after receipt of the request for review.

If the Covered Employee is dissatisfied with the first level review decision, the Covered Employee may request either:

(1) a voluntary second level review; or,
(2) an independent external review.

A voluntary second level review may be requested within 30 days after the receipt of the notice of the first level review decision. If the 30 day deadline for filing the request for second level review ends on a weekday or holiday, the deadline will be extended to the next business day. For a voluntary secondary review, the Company will:

(1) hold a review meeting within 60 days of receiving the request for second level review;
(2) notify the Covered Person in writing at least 20 days in advance of the review date; and
(3) not unreasonably deny a request for postponement of the review made by a Covered Employee.

A written notice of the Company's decision will be sent to the Covered Employee within 7 days of completing the second level review meeting.

Written notice of Internal Review decisions will:

(1) explain the reasons for the Company's decision, under the terms of the Policy and any internal guidelines;
(2) provide the names and qualifications of the health care professionals involved in any Utilization Review; and offer to provide their clinical explanation and criteria, upon request and without charge; when benefits have been:
    (a) denied because the services are not considered medically necessary; or
    (b) reduced in accord with the Alternative Procedures provision;
(3) describe any further appeal procedures available under this Policy after each level of review; and
(4) describe the claimant's right to access relevant claim information and to bring legal action.

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

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

COLORADO'S EXTERNAL REVIEW PROCESS. A Covered Employee who has completed or exhausted at least one level of the Company's Internal Review Process has the right to request an independent external review of an adverse claim decision involving Utilization Review. Such a review is available through the Colorado insurance commission, when:

(1) the claim is for dental services which would otherwise be payable under this Policy; and
(2) the denial is based on the Company's finding that the dental services were not medically necessary, appropriate or efficient; or
(3) the Company fails to comply with any of the requirements for first level review.

There is no minimum dollar amount for a claim to be eligible for an independent external review.

The review will be performed at Company expense, by a certified independent external review entity (Review Entity). The Review Entity must meet the Colorado Division of Insurance Commissioner's standards concerning its expert reviewers' qualifications; its freedom from conflicts of interest; its timeliness and quality of reviews; and its protection of patient confidentiality.

External Review Request. The Company will send the Covered Employee written instructions and forms for requesting an external review, along with the notice of its adverse decision. An external review may be requested by the claimant, or by the claimant's named representative or treating dentist on his or her behalf. A written request must be sent to the Company within four months after receiving the Company's notice of adverse decision following completion or exhaustion of a first level review; or, within 60 days after receiving the Company's notice of adverse decision following completion of a voluntary second level review. If the deadline for filing an external review request ends on a weekday or holiday, the deadline will be extended to the next business day. It must include the Covered Employee's:

(1) name, address, claim number, and policy number; and
(2) signed consent form to disclose protected health information to the Review Entity.

It may also include any new information that differs significantly from that considered during the internal review process.

If the Company denies the Covered Employee's request for External Review for any reason, a written notice that includes the specific reasons for the denial and provides information about appealing the denial of the request with the Division of Insurance will be sent to the Covered Employee and to the Division of Insurance.

External Review Process. Unless the Company reverses its decision based upon new information, it will forward the request to the Colorado Division of Insurance Commissioner, within two working days after receiving it. The Commissioner will assign the case to an independent external review entity and will notify the Company of this, within two working days after receiving the request. Within one working day after receiving the Commissioner's notice, the Company will inform the claimant of:

(1) the Review Entity assigned to the case; and
(2) the procedure for requesting a change, due to conflict of interest concerns.

The Covered Employee or their designated representative may provide additional information to be considered during the review to the independent external review entity within five working days of receipt of the Company's notice, or more than five working days after such receipt at the Review Entity's discretion. The independent external review entity will forward the additional information to the Company within one working day of their receipt.

Within five working days after receiving the Commissioner's notice of Review Entity assignment, the Company will forward copies of its relevant claim documents to the Review Entity. The Review Entity will send the claimant a list of all materials submitted by the Company, within two working days after receiving them. Upon request, the Company will also provide the claimant copies of all relevant information submitted to the independent external review entity; except for any that are confidential or privileged under state or federal law. If the Company fails to provide the documents and information within the specified time frame, the Review Entity may terminate the external review and make a decision to reverse the Company's adverse decision and immediately notify the claimant, the Company and the Commissioner.

The Review Entity will notify the parties, if any more information is needed to complete their review. Such information must be supplied within five working days of the Review Entity's request.

Within 45 days after receiving the request for external review, the Review Entity will make a decision to uphold or reverse the Company's adverse decision and send a written notice of its decision to:

(1) the claimant, any named representative if applicable, and the treating dentist;
(2) the Colorado Insurance Commissioner; and
(3) the Company.

If the Company's denial of benefits is reversed; then payment must be made within five working days. The Review Entity's decision will be binding upon the parties; unless other remedies are available under state or federal law. The claimant may not file another request for an external review of the same adverse claim decision.

RIGHT OF RECOVERY. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

(1) reduce future benefits until full reimbursement is made; and
(2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to:

(1) the Company's error in processing a claim;
(2) the claimant's receipt of benefits or services under another plan;
(3) fraud or any other reason.

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

NOTICE REQUIRED BY 10-3-1116: This notice has been included to comply with Colorado Insurance Code, 10-3-1116.

A claimant whose claim has been denied in whole or in part, and who has exhausted all administrative remedies provided for under this Policy, will, in the case of claims not governed by ERISA, be entitled to have his or her claim reviewed de novo in any court with jurisdiction. In the case of claims not governed by ERISA, the claimant may also have a trial by jury.

DENTAL CLAIM PROCEDURE
for
PREDETERMINATION OF BENEFITS

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

To use this procedure:

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

DENTAL COVERAGE CONTINUATION

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

RIGHT TO CONTINUE. Insurance may be continued in accord with the following provisions when:

(1) a Covered Person becomes ineligible for Policy coverage due to a Qualifying Event shown below; and
(2) this Policy remains in force.

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

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

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

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

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

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

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

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

(1) **Misconduct.** If the Covered Employee's termination of employment is for gross misconduct, coverage may **not** be continued for the Covered Employee or any Covered Dependents.

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

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

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

The Covered Employee must send the Company a copy of the Social Security Administration's notice of disability status:
(a) within 60 days after they find that the Covered Person is disabled, and before the 18-month continuation period expires; and again
(b) within 30 days after they find that he or she is no longer disabled.

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

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

Medicare Entitlement. If the Covered Employee's eligibility under this Policy ends due to a Qualifying Event and he or she becomes entitled to Medicare after electing COBRA continuation coverage, then coverage may not be continued for the Covered Employee. Coverage may be continued for any Covered Dependents for up to 36 months from date of the first Qualifying Event.

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

NOTICE REQUIREMENTS. The Group Policyholder is required by law to notify the Company within 30 days after the following Qualifying Events:

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

The Covered Employee or other Qualified Beneficiary:

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

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

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

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

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

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

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

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

(2) **Other.** If a Covered Person continues coverage under any other continuation privilege under this Policy; then that continuation period will run concurrently with any COBRA continuation period provided above.

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

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

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

- **DENTAL X-RAYS**
  - x-rays taken for orthodontia are not covered under this provision
  - **Bitewing films**
    - up to one set per calendar year, including any bitewings taken as part of a full mouth series
    - includes any vertical bitewings

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

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

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

- **SEALANTS**
  - one treatment per tooth, no more than once in any 60-month period
  - for Dependent children through age 15
  - for the occlusal surface of unrestored and non-decayed first and second permanent molars only

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

LIST OF COVERED DENTAL PROCEDURES
TYPE 2 PROCEDURES – BASIC SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

LIST OF COVERED DENTAL PROCEDURES
TYPE 3 PROCEDURES – MAJOR SERVICES

- **EXTRACTIONS AND ORAL SURGERY**
  - includes local anesthesia and routine post operative visits
  - extractions of asymptomatic teeth, except third molars (wisdom teeth), are not covered
  - extractions and surgical exposure of teeth, when related to orthodontic treatment, are not covered under this provision; however, if Covered Dental Procedures include orthodontic procedures, there may be coverage under that provision
  - **Surgical removal of erupted tooth**
  - **Removal of impacted tooth** (soft tissue, partially or completely bony)
  - **Surgical exposure of impacted or unerupted tooth,** to aid eruption
  - **Excision of hyperplastic tissue**
  - **Excision of pericoronal gingiva**
  - **Removal of exposed roots**
  - **Surgical removal of residual tooth roots**
  - **Excision of lesions, malignant or benign tumors**
  - **Radical resection of bone for tumor with bone graft**
  - **Incision and removal of foreign body from soft tissue**
  - **Removal of foreign body from bone**
  - **Maxillary sinusotomy for removal of tooth fragment or foreign body**
  - **Suture of soft tissue wound**
    - excludes closure of surgical incisions
  - **Incision and drainage of abscess**
  - **Frenulectomy**
  - **Sialolithotomy and Sialodochoplasty**
  - **Dilation of salivary duct**
  - **Sequestrectomy for osteomyelitis or bone abscess**
  - **Closure of fistula,** salivary or oroantral
  - **Reimplantation of tooth or tooth bud due to an accident**
  - **Alveolectomy** (with or without extractions)
  - **Vestibuloplasty**
  - **Removal of exostosis of the maxilla or mandible**
    - includes removal of tori

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

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

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

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

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

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

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

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

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

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

- **PROSTHODONTICS – Fixed or Removable**
  Services to replace teeth extracted or accidentally lost while covered under this Policy
  - includes adjustments, within six months of the placement date
  - benefits are not payable for temporary or provisional services
  - **Bridge abutments and pontics (fixed)**
    - replacement excluding a dental implant is limited to one time in any eight consecutive years from the placement date of the same or any other type of prosthetic at the same site, unless replacement is required due to an accidental Injury
  - **Dentures, complete** (upper or lower) **or partial** (upper or lower) **or unilateral partial (removable)**
    - fees for partial dentures include all conventional clasps, rests and teeth
    - includes addition of teeth or clasp(s) to an existing partial denture to replace natural teeth extracted or accidentally lost while covered under this Policy
    - replacement excluding a dental implant is limited to once in any five consecutive years, per denture, from the placement date of the same or any other type of prosthetic at the same site, unless replacement is required due to an accidental Injury, provided the existing denture is not serviceable
  - **Adjustments to dentures**, more than six months after installation
  - **Tissue conditioning**
    - one per arch per calendar year
  - **Reline of complete or partial denture**
    - one per calendar year, per denture
  - **Rebase of complete or partial denture**
    - once in any 5-year period, per denture

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

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

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

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

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

PRIOR PLAN CREDIT

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

(1) the Schedule of Benefits shows that the Prior Plan Credit provision applies;
(2) the Covered Person is covered under:
    (a) the Group Policyholder's/Participating Employer's prior group dental plan; or
    (b) the prior dental plan of an affiliate or an entity acquired by the Group Policyholder after this Policy's effective date;

    on the day before Dental Expense Benefits under this Policy take effect for the Group Policyholder, affiliate, or acquired company; and
(3) the Covered Person immediately becomes covered under this dental plan on the day the Group Policyholder's/Participating Employer's, affiliate's, or acquired company's Dental Expense Benefits under this Policy take effect.

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

(1) Orthodontia Benefits paid by the prior plan will be applied toward the Lifetime Maximum for Type 4 services (Child Orthodontia) under this Policy.
(2) The Covered Person's continuous months of coverage under the prior plan just before it terminated will count toward this Policy's Benefit Waiting Period for Type 2 services (Basic Care) or Type 3 services (Major Care), if any.
(3) The Covered Person's continuous months of coverage under the prior plan just before it terminated will also count toward any Benefit Waiting Period for Type 4 services (Child Orthodontia) under this Policy; but only if both the prior plan and this Policy provide orthodontia benefits.
(4) Expense that the Covered Person incurs for initial placement of a prosthetic appliance or fixed bridge will be covered; provided:
    (a) the placement is needed to replace one or more natural teeth extracted while insured for Dental Expense Benefits under this Policy or under the prior plan;
    (b) the replacement would have been covered under the prior plan; and
    (c) the extracted teeth are not third molars (wisdom teeth).

POLICY AMENDMENT

DOMESTIC PARTNER COVERAGE

The definition of a DEPENDENT is amended to include the Covered Employee's Domestic Partner. The Covered Employee's Domestic Partner may be enrolled for Dependent coverage under the Policy, in the same manner as a Spouse.

DEFINITION. "Domestic Partner" means the Covered Employee's partner, of the same or the opposite sex**,** when all of the following conditions are met. The Covered Employee and his or her partner:

1. are not under age 18; mentally incompetent; legally married to someone else; or related to the other by blood, to a degree that would bar legal marriage.
2. are living together as each other's sole Domestic Partner; and intend to do so indefinitely.
3. are jointly responsible for each other's welfare and financial obligations, including basic living expenses.
4. are in an exclusive, committed homosexual or heterosexual relationship with each other.

PROOF. To be eligible for Domestic Partner Coverage under the Policy, the Covered Employee and his or her Domestic Partner may be required to furnish one or more of the following:

1. driver's licenses or passports showing a joint residence;
2. canceled rent checks, a joint-tenancy lease or jointly-held mortgage;
3. federal income tax return(s) listing one as a dependent of the other;
4. titles to real or personal property, joint bank account statements or joint loans; or
5. any other evidence which the Company may reasonably request to show joint residency and joint financial responsibilities.

ELIGIBILITY. The Covered Employee becomes eligible for Domestic Partner Coverage on the latest of:

1. the effective date of this Domestic Partner Coverage amendment;
2. the date the Covered Employee becomes eligible for Personal Insurance under the Policy; or
3. the date the Covered Employee and his or her partner begin living together as Domestic Partners.

The Covered Employee may then make written application for Dependents Insurance, in accord with the terms of the Policy.

TERMINATION. A domestic partnership may end due to a partner's death, change in residency or financial arrangements, or for other reasons. When the domestic partnership ends for any reason, the Covered Employee:

1. must give the Group Policyholder written notice within 30 days after the partnership ends; and
2. may not enroll a new Domestic Partnership for 6 months following that notice.

TAX AND LEGAL EFFECTS. The Covered Employee should seek counseling concerning the tax and legal effects of enrolling for Domestic Partner Coverage.

This amendment takes effect on the date the Policy coverage takes effect. In all other respects, the Policy remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

Charles A. Bradley

Officer of the Company

DIRECTORY OF DENTAL FORMS

SECTION NAME:	**LOCATION WITHIN CURRENT POLICY:**
Schedule of Benefits (Who Pays What)	• Schedule of Benefits
Title Page (Cover Page)	• Face Page
Contact Us	• Face Page
Table of Contents	• Table of Contents
Eligibility	• Eligibility and Effective Dates for Employee Dental Coverage; • Eligibility/Effective Dates for Dependent Dental Coverage, if applicable.
How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)	• Schedule of Benefits
Benefits/Coverage (What is Covered)	• Dental Expense Benefits; • Alternative Procedures; • List of Covered Dental Procedures; • Prior Plan Credit, if applicable; • Continuity of Coverage, if applicable.
Limitations/Exclusions (What is Not Covered and Pre-Existing Conditions)	• Limitations and Exclusions
Member Payment Responsibility	• Schedule of Benefits; • Rollover of Calendar Year Maximum, if applicable.
Claims Procedure (How to File a Claim)	• Claim Procedures for Dental Coverage.
General Policy Provisions	• General Provisions
Termination/Nonrenewal/Continuation	• Termination of Employee Dental Coverage; • Termination of Dependent Dental Coverage, if applicable; • Policy Termination; • Provisions Applicable to Participating Employers, if applicable; • Dental Coverage Continuation.
Appeals and Complaints	• Claim Procedures for Dental Coverage.
Information on Policy and Rate Changes	• General Provisions; • Premiums and Premium Rates.
Definitions	• Definitions

SUMMARY OF THE LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

INTRODUCTION

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

IMPORTANT DISCLAIMER

The Life and Health Insurance Protection Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require residency in Colorado. You should not rely on coverage by the Life and Health Insurance Protection Association in selecting an insurance company or in selecting an insurance policy.
Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk.
Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the association to induce you to purchase any kind of insurance policy.

SUMMARY

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

Coverage. Generally, individuals will be protected by the Life and Health Insurance Protection Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state. Certain parties to structured settlement annuity contracts may be entitled to coverage benefits as well based on defined circumstances.

This Information is Provided By:	
Life and Health Insurance Protection Association P.O. Box 36009 Denver, CO 80236 (303) 292-5022	Colorado Division of Insurance 1560 Broadway Suite 850 Denver, CO 80202 (303) 894-7499

Exclusions From Coverage. Persons holding such policies or contracts are not protected by this Association if:

- they are not residents of the State of Colorado, except under certain very specific circumstances;
- the insurer was not authorized or licensed to do business in Colorado at the time the policy or contract was issued;
- their policy was issued by a nonprofit hospital or health service corporation, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy or reinsurance (unless an assumption certificate was issued);
- plans of employers, associations or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- interest rate yields, crediting rate yields or other factors employed in calculating returns, including but not limited to indexes or other external references stated in the policy or contract, that exceed an average rate specified in the association Act;
- dividends;
- experience rating credits;
- credits given in connection with the administration of a policy or contract;
- any unallocated annuity;
- annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
- policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;
- sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;
- unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- policies or contracts issued by an insurer which was insolvent or unable to fulfill its contractual obligations as of July 1, 1991, except for annuity contracts issued by a member insurer which was placed into liquidation between July 1, 1991 and August 31, 1991;
- policies or contracts covering persons who are not citizens of the United States;
- any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by the separate entity.

Limits On Amount of Coverage. The Act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were issued by the same company, even if such contracts provided different types of coverages, the Association will pay a maximum of:

- $300,000 in net life insurance death benefits and no more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;
- for health insurance benefits, $100,000 for coverages not defined as disability, basic hospital, medical and surgical, or major medical insurance, including any net cash surrender and net cash withdrawal values; $300,000 for disability insurance; or $500,000 for basic hospital, medical and surgical, or major medical insurance;
- $250,000 in the present value of annuity of annuity benefits, including net cash surrender and net cash withdrawal values; or
- with respect to each payee of a structured settlement annuity, $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values; or
- $300,000 for long term care benefits.

The Association shall not be liable to expend more than $300,000 in the aggregate, with respect to any one life except that with respect to benefits for basic hospital, medical and surgical and major medical insurance, the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual.