

**GENE B GLICK
COMPANY INC
INDIANAPOLIS IN**

**Dental Benefit Summary Plan
Description
7670-02-410719**

Revised 08-01-2023

BENEFITS ADMINISTERED BY



A UnitedHealthcare Company

TABLE OF CONTENTS

INTRODUCTION.....	1
PLAN INFORMATION.....	2
SCHEDULE OF BENEFITS.....	4
OUT-OF-POCKET EXPENSES AND MAXIMUMS.....	5
ELIGIBILITY AND ENROLLMENT.....	6
SPECIAL ENROLLMENT PROVISION.....	10
TERMINATION.....	12
COBRA CONTINUATION OF COVERAGE.....	14
UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994.....	22
PROVIDER NETWORK.....	23
ALTERNATE BENEFITS PROVISION.....	24
PRE-TREATMENT ESTIMATE OF BENEFITS.....	25
COVERED EXPENSES.....	26
ORTHODONTIC BENEFITS PROVISION.....	41
COORDINATION OF BENEFITS.....	44
RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET PROVISION.....	47
GENERAL EXCLUSIONS.....	50
CLAIMS AND APPEAL PROCEDURES.....	52
FRAUD.....	59
OTHER FEDERAL PROVISIONS.....	60
HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION.....	61
STATEMENT OF ERISA RIGHTS.....	65
PLAN AMENDMENT AND TERMINATION INFORMATION.....	67
GLOSSARY OF TERMS.....	68

GENE B GLICK COMPANY INC
GROUP DENTAL BENEFIT PLAN
SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on benefits available under this Plan, as well as information on a Covered Person's rights and obligations under the GENE B GLICK COMPANY INC Dental Benefit Plan (the "Plan"). As a valued Employee of GENE B GLICK COMPANY INC, we are pleased to sponsor this Plan to provide benefits that can help meet Your dental care needs. Please read this document carefully and contact Your Human Resources if You have questions.

GENE B GLICK COMPANY INC is named the Plan Administrator for this group dental Plan. The Plan Administrator has retained the services of an independent Third Party Administrator, UMR, Inc. (hereinafter "UMR") to process claims and handle other duties for this self-funded Plan. UMR as Third Party Administrator, does not assume liability for benefits payable under this Plan as they are solely claims paying agents for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits. The Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA) and its amendments.

Some of the terms used in this document begin with a capital letter, even though it normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in the Glossary of Terms, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Glossary will help to better understand the provisions of this group dental Plan.

Individuals covered under this Plan will be receiving an identification card to present to the provider whenever services are received. On the back of this card are phone numbers to call in case of questions or problems.

This document summarizes the benefits and limitations of the Plan and will serve as the SPD and Plan document. Therefore it will be referred to as both the Summary Plan Description ("SPD") and Plan document. It is being furnished to You in accordance with ERISA.

This document becomes effective on August 1, 2010.

PLAN INFORMATION

Plan Name	GENE B GLICK COMPANY INC GROUP BENEFITS PLAN
Name And Address Of Employer	GENE B GLICK COMPANY INC 8801 RIVER CROSSING BLVD STE 200 INDIANAPOLIS IN 46240
Name, Address And Phone Number Of Plan Administrator	GENE B GLICK COMPANY INC 8801 RIVER CROSSING BLVD STE 200 INDIANAPOLIS IN 46240 317-469-5867
Named Fiduciary	GENE B GLICK COMPANY INC
Employer Identification Number Assigned By The IRS	35-0924178
Plan Number Assigned By The Plan	501
Type Of Benefit Plan Provided	Self-Funded Health & Welfare Plan providing Group Dental Benefits
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for dental claims.
Name And Address Of Agent For Service Of Legal Process	GENE B GLICK COMPANY INC 8801 RIVER CROSSING BLVD STE 200 INDIANAPOLIS IN 46240
Funding Of The Plan	Employer and Employee Contributions Benefits are provided by a benefit plan maintained on a self-insured basis by Your employer.
Benefit Plan Year	Benefits begin on August 1 and end on the following July 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through July 31 of the same Benefit Plan Year.
ERISA Plan Year	August 1 through July 31
ERISA And Other Federal Compliance	It is intended that this Plan meet all applicable requirements of ERISA and other federal regulations. In the event of any conflict between this Plan and ERISA or other federal regulations, the provisions of ERISA and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, including this Summary Plan Description (SPD), and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrator for this Plan. Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrator shall be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or Third Party Administrator shall be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrator make, in its sole discretion, and further means that the Covered Person consents to the limited standard and scope of review afforded under law.

SCHEDULE OF BENEFITS

Benefit Plan 001

Benefits for You and Your Dependents are listed below.

SUMMARY OF BENEFITS	
Maximums	Individual
<ul style="list-style-type: none">• Plan Year Benefit Maximum includes Preventive and Diagnostic Services, Basic Services, and Major Services	\$3,000.00
<ul style="list-style-type: none">• Lifetime Orthodontic Maximum Dependent Children Only	\$1,500.00
<ul style="list-style-type: none">• Plan Year Benefit Maximum for Oral Surgery Procedures	\$3,000.00
Participation Percentage	The Plan Pays
<ul style="list-style-type: none">• Preventive and Diagnostic Services	100%
<ul style="list-style-type: none">• Basic Services	80%
<ul style="list-style-type: none">• Major Services	50%
<ul style="list-style-type: none">• Orthodontic	50%

OUT-OF-POCKET EXPENSES AND MAXIMUMS

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person and the Plan each pay a percentage of the Covered Expenses. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts as applicable.

ADDITIONAL OUT-OF-POCKET EXPENSES

In addition to the Plan Participation percentage, the Covered Person is also responsible for the following costs:

- Any remaining charges due to the provider after the Plan's benefits are determined.
- Full charges for services that are not covered benefits under this Plan.
- Legal fees and interest charged by a provider.
- The difference between the provider's contracted fee for the service that was actually provided, and the fee for the Alternate Benefit that the Plan approved.
For example: If the provider placed a resin (white) filling in Your tooth, but a amalgam (silver) filling would be sufficient to restore the tooth, You will need to pay the difference between the cost of the resin filling and the amalgam filling.

INDIVIDUAL PLAN YEAR MAXIMUM BENEFIT

All Covered Expenses will count toward the Covered Person's individual Plan Year Maximum Benefit that is shown on the Schedule of Benefits, as applicable.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses cannot be waived by a provider under any "fee forgiveness", "not out-of-pocket" or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. The Plan may request documentation from You or Your Dependents in order to make these determinations. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

WAITING PERIOD

If eligible, You must complete a Waiting Period before coverage becomes effective for You and Your Dependents. A Waiting Period is a period of time that must pass before an Employee or Dependent becomes eligible for coverage under the terms of this Plan.

You are eligible for coverage on the date listed below under the Effective Date section, upon completion of **one** calendar **month** of regular employment in a covered position.

The start of Your Waiting Period is the first full day of employment at the job that made You eligible for coverage under this Plan.

ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works 30 or more hours per week ([the Plan will grandfather those employees who are working between 20 and 30 hours prior to 08-01-2013](#)), is a member of the Board of Directors or the Chairman of the Board Emeritus, but for purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Leased Employees.
- An Independent Contractor as defined in this Plan.
- A consultant who is paid on other than a regular wage or salary by the employer.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, shall change a person's eligibility for benefits.

An **eligible Dependent** includes:

- Your legal spouse provided he or she is not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse does not include a Common-Law Marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator.

- A Dependent Child until the Child reaches his or her 26th birthday. The term “**Child**” includes the following Dependents:
 - A natural biological Child;
 - A step Child;
 - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
 - A Child under Your (or Your Spouse’s permanent or temporary Legal Guardianship as ordered by a court;
 - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO);

- A Dependent does not include the following:
 - A foster Child;
 - A Child of a Domestic Partner or under Your Domestic Partner’s Legal Guardianship;
 - A grandchild;
 - Domestic Partners;
 - A Dependent Child if the Child is covered as a Dependent of another Employee at this company;
 - Any other relative or individual unless explicitly covered by this Plan.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible Employee shall not also be considered an eligible Dependent under this Plan.

RIGHT TO CHECK A DEPENDENT’S EMPLOYMENT STATUS: The Plan reserves the right to check the employment status of a Dependent at any time throughout the year. You and Your Dependent have an obligation to notify the Plan should the Dependent’s employment status change during the Plan Year. Please notify Your Human Resources Department regarding status changes.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child’s 26th birthday; or
- The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a Special Enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

and the Dependent Child fits either of the following two categories:

- If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child’s health coverage may continue beyond the day the Child would otherwise cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 31 calendar days after the day coverage for the Dependent would normally end. The Plan may, for two years, ask for additional proof at any time, after which the Plan may ask for proof not more than once a year. Coverage may continue subject to the following minimum requirements:
 - The Dependent must not be able to hold a self-sustaining job due to the disability; and
 - Proof of the disability must be submitted as required (Notice of Award of Social Security Income is acceptable); and
 - The Employee must still be covered under this Plan.

A Dependent Child who has not attained the age of 30 may re-enroll in the Plan on the day of the event, subject to the Plan terms if the Dependent Child becomes Totally Disabled. In this case, written proof that the Dependent Child is Totally Disabled must be submitted along with the enrollment form.

IMPORTANT It is Your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of Totally Disabled, the Plan has the right to be reimbursed from the Dependent or Employee for any dental claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Continuation of Coverage section in this document.

Employees have the right to choose which eligible Dependents are covered under the Plan.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of:

- If You apply within Your Waiting Period, Your coverage will become effective the first day of the month following the date You complete Your Waiting Period. If Your Waiting Period ends on the first day of the month, Your coverage will not begin until the first day of the following month.
- If You apply after the completion of Your Waiting Period, You will be considered a Late Enrollee. Coverage for a Late Enrollee will become effective August 1 following application during the annual open enrollment period. (Persons who apply under the Special Enrollment Provision are not considered Late Enrollees).
- If You are eligible to enroll under the Special Enrollment Provision. Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 31 days of the event.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of:

- The date Your coverage with the Plan begins if You enroll the Dependent at that time; or
- The date You acquire Your Dependent if application is made within 31 days of acquiring the Dependent; or
- August 1 following application during the annual open enrollment period. The Dependent will be considered a Late Enrollee if You request coverage for Your Dependent more than 31 days after Your hire date, or more than 31 days following the date You acquire the Dependent; or
- If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 31 days following the event; or
- The later of the date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

A contribution will be charged from the first day of coverage for the Dependent, if additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

ANNUAL OPEN ENROLLMENT PERIOD

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Eligible Employees and their Dependents who enroll during the annual open enrollment period will be considered Late Enrollees. Covered Employees will be able to make a change in coverage for themselves and their eligible Dependents.

Coverage Waiting Periods are waived during the annual open enrollment period for covered Employees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If You and/or Your Dependent become covered under this Plan as a result of electing coverage during the annual open enrollment period, the following shall apply:

- The annual open enrollment period shall typically be [held in June](#). The employer will give eligible Employees written notice prior to the start of an annual open enrollment period; and
- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and
- The Effective Date of coverage shall be August 1 following the annual open enrollment period.

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

This Plan gives eligible persons special enrollment rights under this Plan if there is a loss of other dental coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

LOSS OF DENTAL COVERAGE

Current Employees and their Dependents may have a special opportunity to enroll for coverage under this Plan if there is a loss of other coverage.

If the following conditions are met:

- You and/or Your Dependents were covered under a group dental plan or dental insurance policy at the time coverage under this Plan is offered; and
- The coverage under the other group dental plan or dental insurance policy was:
 - COBRA continuation coverage and that coverage was exhausted; or
 - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
 - Terminated and no substitute coverage is offered; or
 - Exhausted due to an individual meeting or exceeding a lifetime limit on all benefits; or
 - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 31 calendar days after the date the other coverage ended.

- You and/or Your Dependents were covered under a Medicaid plan or state child health plan and Your or Your Dependents coverage was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

You or Your Dependents may not enroll for dental coverage under this Plan due to loss of dental coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact, or
- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries and other eligible persons have a special opportunity to enroll for coverage under this Plan if there is a change in family status.

If a person becomes Your eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse and newly acquired Dependent(s) who are not already enrolled, may enroll for dental coverage under this Plan during a special enrollment period. You must request and apply for coverage within 31 calendar days of marriage, birth, adoption or Placement for Adoption.

NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

Current Employees and their Dependents may be eligible for a Special Enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependent is determined to be eligible for such assistance.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective:

- In the case of marriage, on the date of the marriage (Note: Eligible individuals must submit their enrollment forms prior to the Effective Date of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or
- In the case of a Dependent's birth, on the date of such birth; or
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the date the approved request for coverage is received; or
- In the case of loss of coverage, on the date following loss of coverage.

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Please refer to the employer's Section 125 Cafeteria Plan for more information.

TERMINATION

For information about continuing coverage, refer to the COBRA section of this SPD.

EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment, or at annual open enrollment periods; or
- The end of the stability period in which You became a member of a non-covered class, as determined by the employer except as follows:
 - An employee on approved leave of absence, STD or administrative leave may continue their group medical coverage for up to 6 months from the last day of active work. Employee contributions must be paid during this period. Eligibility and coverage will end at the earliest of: (1) when the approved leave ends, (2) at the end of 6 months or (3) when contributions for the coverage are not made timely.
 - If You are temporarily absent from work due to active military duty, refer to USERRA under the USERRA section; or
- The day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends; or
- The day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the Employee resides; or
- The last day of the month in which Your Dependent Child attains the limiting age of 26 listed under the Eligibility section, unless the Child qualifies for Extended Dependent Coverage; or
- If Your Dependent Child qualifies for Extended Dependent Coverage as Totally Disabled, the end of the year in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or

- The day of the month in which Your Dependent Child no longer satisfies a required eligibility criteria listed in the Eligibility and Enrollment section; or
- The date Dependent coverage is no longer offered under this Plan; or
- The end of the year in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment, or at annual open enrollment periods; or
- The date in which the Dependent becomes covered as an Employee under this Plan; or
- The date You or Your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

- it has only a prospective effect; or
- it is attributable to non-payment of premiums or contributions; or
- it is initiated by You or Your personal representative.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 13-week period, You will be treated as a new hire and will be required to meet all the requirements of a new Employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your Human Resources or Personnel office.

COBRA CONTINUATION OF COVERAGE

Important. Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You and Your Dependent(s) need to do to protect the right to receive it. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all of the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You or Your Dependent(s) as required.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on Your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group health plan for which You are eligible (such as a spouse's plan), even if that plan generally does not accept Late Enrollees.

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries, (defined below), the right to continue their health care benefits (including dental benefits) beyond the date that they might otherwise terminate. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event, outlined below. When a Qualifying Event causes (or will cause) a Loss of Coverage, then the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

An Employee will become a Qualified Beneficiary if coverage under the Plan is lost because either one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• Your employment ends for any reason other than Your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage can be extended. See the section below entitled "The Right to Extend Coverage" for more information.)

The spouse of an Employee will become a Qualified Beneficiary if coverage is lost under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• Your spouse dies	up to 36 months
• Your spouse's hours of employment are reduced	up to 18 months
• Your spouse's employment ends for any reason other than his or her gross misconduct	up to 18 months
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• You become divorced or legally separated from Your spouse	up to 36 months

The Dependent Children of an Employee become Qualified Beneficiaries if coverage is lost under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• The parent-Employee dies	up to 36 months
• The parent-Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The parent-Employee's hours of employment are reduced	up to 18 months
• The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The Child stops being eligible for coverage under the Plan as a Dependent	up to 36 months

Note: A spouse or Dependent Child newly acquired (newborn or adopted) during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent, other than a newborn or newly adopted Child, acquired and enrolled after the original Qualifying Event, is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

COBRA NOTICE PROCEDURES

NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

To be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrators, either Your employer or the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information: (A form to notify the COBRA Administrator is available upon request.)

- The Qualified Beneficiary's name, their current address and complete phone number,
- The group number, name of the employer that the Employee was with,
- Description of the Qualifying Event (i.e., the life event experienced), and
- The date that the Qualifying Event occurred or will occur.

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes in the addresses of family members. Keep a copy of any notices sent to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice to the COBRA Administrator when coverage terminates due to Qualifying Events that are the Employee's termination of employment or reduction in hours, death of the Employee, or the Employee becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days when these events occur.

EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of other Qualifying Events that are divorce or legal separation of the Employee and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a Loss of Coverage) due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, covered Employee or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE GROUP DENTAL COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that must be completed to elect to continue group dental coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing to continue group dental coverage and must make the required payments when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group dental coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services that the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group dental coverage will be reinstated back to the date coverage was lost, provided that the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will be effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contribution. This may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once a year.

If Your employer offers annual open enrollment opportunities for active Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage, however the Qualified Beneficiary will receive specific payment information including due dates when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, then the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA administrator receives a check that is missing information or has discrepancies regarding the information on the check (i.e., the numeric dollar amount does not match the written dollar amount), the COBRA administrator will provide a notice to the Qualified Beneficiary with information regarding what needs to be done to correct the mistake.

Note: Payment will not be considered made if a check is returned for non-sufficient funds.

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, after any of the following events occur, written notice to the COBRA Administrator is required within 30 calendar days of:

- The date any Qualified Beneficiary marries. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.
- The date a Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.
- The date of a final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.
- The date any Qualified Beneficiary becomes covered by another group dental plan.
- Additionally, if the COBRA administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information in the timeframe outlined in the request document.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents. 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children would be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)
- For Dependents only. 36 months from the Qualifying Event if coverage is lost due to one of the following events:
 - Employee's death.
 - Employee's divorce or legal separation.
 - Former Employee becomes enrolled in Medicare.
 - A Dependent Child no longer being a Dependent as defined in the Plan.

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided that written notice to the COBRA Administrator is given as soon as possible but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled either before becoming eligible for, or within the first 60 days of being covered by, COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualifying Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA administrator a copy of the Social Security Administration letter of disability determination before the end of the initial 18-month period and within 60 days of the later of:

- The date of the SSA disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Events: (Dependents Only) If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (part A, part B or both) or is divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event or in the case of a newborn Child being added as a result of a HIPAA special enrollment right. A Dependent acquired during COBRA continuation (other than newborns and newly adopted Children) is not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will only lead to the extension when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group dental plan for any Employees. (Note that if the employer terminates the group dental plan that the Qualified Beneficiary is under, but still maintains another group dental plan for other similarly-situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group dental plan, although benefits and costs may not be the same).
- The required contribution for the Qualified Beneficiary's coverage is not paid on time.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled with Medicare.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group dental plan.
- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.
- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE (Read This If Thinking Of Declining COBRA Continuation Coverage)

At the time of a COBRA Qualifying Event, a Qualified Beneficiary has two primary options. The first is to waive his or her right to COBRA and make an election for coverage, whether group health coverage or insurance coverage through the individual market or the exchanges, in accordance with his or her HIPAA special enrollment rights. Please refer to the Special Enrollment section for further details. The second option is to elect COBRA continuation coverage. If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose his or her special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary as it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with his or her HIPAA special enrollment rights.

DEFINITIONS

Qualified Beneficiary means a person covered by this group dental Plan immediately before the Qualifying Event who is the Employee, the spouse of a covered Employee or the Dependent Child of a covered Employee. This includes a Child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered Employee.

- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered Employee.
- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).
- The covered former Employee becomes enrolled in Medicare.
- A Dependent Child no longer being a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before the Qualifying Event. Loss of Coverage includes change in coverage terms, change in plans, termination of coverage, partial Loss of Coverage, increase in Employee cost, as well as other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after the Qualifying Event, but it must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, and for more information about COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

The Plan Administrator:
 GENE B GLICK COMPANY INC
 8801 RIVER CROSSING BLVD STE 200
 INDIANAPOLIS IN 46240

The COBRA Administrator

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in loss of coverage as a result of active duty. Employees on leave for military service must be treated like they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leave of absence or furlough. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following the military leave of absence cannot be subject to Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under USERRA is the lesser of:

- 24 months beginning on the day that the Uniformed Service leave begins, or
- a period beginning on the day that the Service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if it is otherwise impossible or unreasonable under all the circumstances.

Upon notice of intent to leave for uniformed services, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. For periods of 31 days or longer, if an Employee elects to continue dental coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENT

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will only be deemed eligible for COBRA extension because they are not eligible for a separate, independent right of election under USERRA.

PROVIDER NETWORK

This coverage provides for the use of a provider organization. Benefits are paid at the same level regardless of which provider is chosen, however Dental Benefit Providers, Inc., providers have agreed to provide certain discounts on covered services which reduces the Covered Person's out-of-pocket expenses.

The Plan does not limit a Covered Person's right to choose his or her own dental care if a dental expense is not a Covered Expense under this Plan or is subject to a limitation or Exclusion.

Provider Directory Information

Each covered Employee, those on COBRA, and Children or guardians of Children who are considered alternate recipients under a Qualified Medical Child Support Order, will automatically be given or electronically made available, a separate document, at no cost, that lists the participating network providers for this Plan. The Employee should share this document with other covered individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they should make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

To get more information on, Dental Benefit Providers, Inc., providers, call the number on the back of the Plan's Identification card, or go to the following website:

www.UMR.com

ALTERNATE BENEFITS PROVISION

Many dental conditions can be treated in more than one way. This Plan has an "Alternate Benefits Provision" that governs the amount of benefits that this Plan will pay for covered treatments. If a patient chooses a more expensive treatment than is needed to correct a dental condition according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam (silver) filling is sufficient to restore a tooth, but the patient and the Dentist decide to use a resin (white) filling, the Plan will base its payment on the Usual and Customary Charge or the maximum fee schedule for the amalgam filling. The patient will be responsible for paying the difference in cost.

Alternate Benefits will only be considered for those procedures that specifically state "Alternate Benefit may apply" or "Alternate Benefit will apply" on the Covered Expenses section of this document.

PRE-TREATMENT ESTIMATE OF BENEFITS

One of the advantages of this dental Plan is that it enables the Covered Person to see the amount payable by the Plan prior to having the Dentist begin any extensive treatment. Through this process, Covered Persons can prevent any misunderstandings as to what is covered by the Plan. A Covered Person can accurately estimate what he or she will owe the Dentist. This procedure is known as "Pre-Treatment Estimate of Benefits" and here is how it works:

Usually, before beginning any extensive treatment, the Covered Person will be advised as to what the Dentist intends to do, and this is referred to as the Treatment Plan. The Dentist will submit the Treatment Plan to UMR prior to services being performed. UMR will then notify the Covered Person and the Dentist, in advance, regarding what benefits are payable under this Plan, and how much the Covered Person will be responsible for paying.

Getting a Pre-Treatment Estimate of Benefits is recommended whenever the Dentist's estimated charge is \$500 or more. This feature is not mandatory; however dental care can be expensive. Covered Persons may want to have an idea how much this Plan will pay before agreeing to have the work done.

Note: The Pre-Treatment Estimate is not a guarantee of payment. Benefits are payable if coverage is in effect on the date services are performed (subject to all Plan provisions) and the claim is submitted to the Plan within the timely filing period. If additional procedures are performed, the claim will be reviewed in its entirety.

COVERED EXPENSES

The Plan will pay for the following Covered Expenses Incurred by a Covered Person, subject to any Deductibles, Plan Participation amounts, maximums or limits shown on the Schedule of Benefits, and to all other provisions as stated in this SPD. Benefits are based on the Usual and Customary charge, fee schedule or Negotiated Rate. Any procedure that is not specifically listed as covered is excluded.

General Overview:

This Plan provides dental benefits under several categories of dental services. Within each category, there are a number of subcategories of covered services.

COVERED EXPENSES - PREVENTIVE AND DIAGNOSTIC SERVICES

Diagnostic Services:

Clinical Oral Evaluations

- D0120 Periodic oral evaluation (limited to two per Plan year) (not performed in conjunction with orthodontic treatment)
- D0140 Limited oral evaluation - problem focused
- D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver (limited to two per Plan year) (not performed in conjunction with orthodontic treatment)
- D0150 Comprehensive oral evaluation - new or established patient (limited to two per Plan year) (not performed in conjunction with orthodontic treatment)
- D0160 Detailed and extensive oral evaluation - problem focused, by report
- D0170 Reevaluation - limited, problem focused (Established patient; not post-operative visit) (limited to two per Plan year) (not performed in conjunction with orthodontic treatment)
- D0171 Re-evaluation – post-operative office visit
- D0180 Comprehensive periodontal evaluation - new or established patient (limited to two per Plan year) (not performed in conjunction with orthodontic treatment)
- D0190 Screening of a patient – a screening, including state or federally mandated screenings, to determine an individual's need to be seen by a Dentist for diagnosis.
- D0191 Assessment of a patient - a limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment.

X Rays

- D0210 Intraoral - complete series of radiographic images (including bitewings) (limited to one series every 36 consecutive months, combined with D0330) (a full mouth series includes 4 bitewings and 12 or more periapical x-rays) (not performed in conjunction with orthodontic treatment)
- D0220 Intraoral - periapical - first radiographic image
- D0230 Intraoral - periapical - each additional radiographic image (up to 12) (benefits not to exceed a full mouth series)
- D0240 Intraoral - occlusal radiographic image
- D0250 Extraoral - first radiographic image
- D0260 Extraoral - each additional radiographic image
- D0270 Bitewing - single radiographic image (limited to two visits per year with a maximum of 8 radiographic images per visit)
- D0272 Bitewing - two radiographic images (limited to two visits per year with a maximum of 8 radiographic images per visit)
- D0273 Bitewing - three radiographic images (limited to two visits per year with a maximum of 8 radiographic images per visit)
- D0274 Bitewing - four radiographic images (limited to two visits per year with a maximum of 8 radiographic images per visit)

- D0277 Vertical bitewings - 7 to 8 radiographic images (limited to two visits per year with a maximum of 8 radiographic images per visit)
- D0290 Posterior - anterior or lateral skull and facial bone survey radiographic image
- D0310 Sialography
- D0330 Panoramic radiographic image, including bitewings and periapicals if necessary - (limited to one every 36 consecutive months, combined with D0210) (not performed in conjunction with orthodontic treatment)
- D0350 2D oral/facial photographic images (including intraoral and extraoral images) (not performed in conjunction with orthodontic treatment)
- D0351 3D photographic images

Tests and Laboratory Examinations

- D0415 Collection of microorganisms for culture and sensitivity (may be combined with other services)
- D0460 Pulp vitality tests
- D0470 Diagnostic casts (not performed in conjunction with orthodontic treatment)
- D0472 Accession of tissue, gross examination, preparation and transmission of written report
- D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report
- D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report
- D0480 Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report
- D0486 Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report
- D0502 Other oral pathology procedures, by report
- D7285 Incisional biopsy of oral tissue - hard (bone, tooth)
- D7286 Incisional biopsy of oral tissue - soft
- D7287 Exfoliative cytological sample collection
- D7288 Brush biopsy - transepithelial sample collection

Other Diagnostic

- D9310 Consultation - diagnostic service provided by Dentist or physician other than requesting Dentist or physician
- D9430 Office visit for observation (during regularly scheduled hours - no other services performed)
- D9440 Office visit - after regularly scheduled hours

Preventive Services:

Cleaning and Fluoride Treatments

- D1110 Prophylaxis - adult - age 12 or over (limited to two per Plan year)
- D1120 Prophylaxis - Child - under age 12 (limited to two per Plan year)
- D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients through 18 years of age (limited to one treatment per Plan year)
- D1208 Topical application of fluoride, excluding fluoride - through 18 years of age (limited to one treatment per Plan year)

Other Preventive

- D1351 Sealant - per tooth (Child - under age 19 and only on occlusal surfaces of permanent molars - teeth 2, 3, 14, 15, 18, 19, 30 and 31 once every 36 consecutive months)
- D1352 Preventive resin restoration in a moderate to high caries risk patient- permanent tooth (Child - under age 19 and only on occlusal surfaces of permanent molars - teeth 2, 3, 14, 15, 18, 19, 30 and 31 once every 36 consecutive months)
- D1353 Sealant repair – per tooth

D9110 Palliative (emergency) treatment of dental pain - minor procedures - no operative procedures performed

Space Maintenance - (passive appliances) - limited to Child - under age 19

D1510 Space maintainer - fixed - unilateral

D1515 Space maintainer - fixed - bilateral

D1520 Space maintainer - removable - unilateral

D1525 Space maintainer - removable - bilateral

D1550 Recement or rebond space maintainer

D1555 Removal of fixed space maintainer

Minor Treatment To Control Harmful Habits

D8210 Removable appliance therapy (not performed in conjunction with orthodontic treatment)

D8220 Fixed appliance therapy (not performed in conjunction with orthodontic treatment)

COVERED EXPENSES - BASIC SERVICES

Restorations (including polishing) - multiple restorations on one surface will be considered as a single restoration

- D2140 Amalgam - one surface, primary or permanent
- D2150 Amalgam - two surfaces, primary or permanent
- D2160 Amalgam - three surfaces, primary or permanent
- D2161 Amalgam - four or more surfaces, primary or permanent

- D2330 Resin-based composite - one surface, anterior (teeth 4-13 and 20-29) (Alternate Benefit may apply)
- D2331 Resin-based composite - two surfaces, anterior (teeth 4-13 and 20-29) (Alternate Benefit may apply)
- D2332 Resin-based composite - three surfaces, anterior (teeth 4-13 and 20-29) (Alternate Benefit may apply)
- D2335 Resin-based composite - four or more surfaces or involving incisal angle, anterior (teeth 4-13 and 20-29) (Alternate Benefit may apply)
- D2390 Resin-based composite crown, anterior (Alternate Benefit may apply)
- D2391 Resin-based composite - one surface, posterior (Alternate Benefit may apply)
- D2392 Resin-based composite - two surfaces, posterior (Alternate Benefit may apply)
- D2393 Resin-based composite - three surfaces, posterior (Alternate Benefit may apply)
- D2394 Resin-based composite - four or more surfaces, posterior (Alternate Benefit may apply)

Other Basic Restorative Services

- D2970 Temporary crown (fractured tooth)
- D6092 Recement or rebond implant/abutment-supported crown
- D6093 Recement or rebond implant/abutment-supported fixed partial denture
- D6973 Core buildup for retainer, including any pins

Pulp Capping

- D3110 Pulp cap - direct (excluding final restoration)
- D3120 Pulp cap - indirect (excluding final restoration)

Pulpotomy

- D3220 Therapeutic pulpotomy - (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament
- D3221 Pulpal debridement, primary and permanent teeth
- D3222 Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development

Endodontic Therapy on Primary Teeth

- D3230 Pulpal therapy (resorbable filling) anterior, primary tooth - excluding final restoration (Alternate Benefit may apply)
- D3240 Pulpal therapy (resorbable filling) posterior, primary tooth - excluding final restoration (Alternate Benefit may apply)

Endodontic Therapy (including Treatment Plan, clinical procedures and follow-up care)

Benefits for root canals in baby teeth are limited to a benefit for a pulpotomy.

- D3310 Anterior (excluding final restoration)
- D3320 Bicuspid (excluding final restoration)
- D3330 Molar (excluding final restoration)
- D3331 Treatment of root canal obstruction; non-surgical access
- D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth
- D3333 Internal root repair of perforation defects
- D3346 Retreatment of previous root canal therapy - anterior
- D3347 Retreatment of previous root canal therapy - bicuspid
- D3348 Retreatment of previous root canal therapy - molar
- D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.). If over age 11 no benefit if performed within 12 months of root canal.
- D3352 Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).
- D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.). If over age 11 no benefit if performed within 12 months of root canal.
- D3354 Pulpal regeneration - (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration - (includes removal of intra-canal medication and procedures necessary to regenerate continued root development and necessary radiographs. If over age 11 no benefit if performed within 12 months of root canal.

Apicoectomy/Periapical Services

- D3410 Apicoectomy/periradicular surgery - anterior
- D3421 Apicoectomy/periradicular surgery - bicuspid (first root)
- D3425 Apicoectomy/periradicular surgery - molar (first root)
- D3426 Apicoectomy/periradicular surgery (each additional root)
- D3430 Retrograde filling - per root
- D3450 Root amputation - per root

Other Endodontic Procedures

- D3910 Surgical procedures for isolation of tooth with rubber dam
- D3920 Hemisection (including any root removal) not including root canal therapy
- D3950 Canal preparation and fitting of preformed dowel or post

Surgical Services (including the usual postoperative services)

- D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant - limited to four quadrants per Treatment Plan
- D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant
- D4212 Gingivectomy or gingivoplasty - to allow access for restorative procedure, per tooth
- D4230 Anatomical crown exposure - four or more contiguous teeth per quadrant
- D4231 Anatomical crown exposure - one to three teeth per quadrant
- D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant - limited to four quadrants per Treatment Plan
- D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant
- D4245 Apically positioned flap
- D4249 Clinical crown lengthening - hard tissue

- D4260 Osseous surgery (including evaluation of a full thickness flap and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant - limited to four quadrants per Treatment Plan
- D4261 Osseous surgery (including evaluation of a full thickness flap and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant
- D4263 Bone replacement graft - first site in quadrant
- D4264 Bone replacement graft - each additional site in quadrant
- D4265 Biologic materials to aid in soft and osseous tissue regeneration
- D4266 Guided tissue regeneration - resorbable barrier, per site
- D4267 Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)
- D4268 Surgical revision procedure, per tooth
- D4270 Pedicle soft tissue graft procedure
- D4273 Subepithelial connective tissue graft procedures, per tooth
- D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in same anatomical area)
- D4275 Soft tissue allograft
- D4276 Combined connective tissue and double pedicle graft, per tooth
- D4277 Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft
- D4278 Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site

Other Periodontal Services

- D4341 Periodontal scaling and root planing - four or more teeth per quadrant - limited to four quadrants per Treatment Plan
- D4342 Periodontal scaling and root planing - one to three teeth, per quadrant
- D4355 Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis (limited to six months from cleaning, or 12 months from any other periodontal services, whichever is later).
- D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report
- D4910 Periodontal maintenance. No benefit if performed within three months of periodontal surgery (limited to one treatment every three consecutive months)
- D4920 Unscheduled dressing change (by someone other than treating Dentist)
- D9940 Occlusal guard, by report (only in conjunction with periodontal surgery or bruxism - limited to one every five years)
- D9942 Repair and/or relines of occlusal guard (only in conjunction with periodontal surgery)
- D9951 Occlusal adjustment - limited (only in conjunction with periodontal surgery or bruxism - limited to four quadrants per Treatment Plan)
- D9952 Occlusal adjustments - complete (only in conjunction with periodontal surgery or bruxism - limited to four quadrants per Treatment Plan - limited to once every 24 consecutive months)
- D9971 Odontoplasty 1-2 teeth; includes removal of enamel projections (only in conjunction with active periodontal treatment or bruxism)

Adjustment to Dentures - Separate benefits are allowed only after six months following installation of denture

- D5410 Adjust complete denture - maxillary
- D5411 Adjust complete denture - mandibular
- D5421 Adjust partial denture - maxillary
- D5422 Adjust partial denture - mandibular

Denture Rebase Procedures - Separate benefits for rebase are allowed only after six months following installation of dentures or partials (limited to one every 36 consecutive months)

- D5710 Rebase complete maxillary denture
- D5711 Rebase complete mandibular denture
- D5720 Rebase maxillary partial denture
- D5721 Rebase mandibular partial denture

Denture Reline Procedures - Separate benefits for relines are allowed only after six months following installation of dentures and partials (limited to one every 12 consecutive months)

- D5730 Reline complete maxillary denture (chairside)
- D5731 Reline complete mandibular denture (chairside)
- D5740 Reline maxillary partial denture (chairside)
- D5741 Reline mandibular partial denture (chairside)
- D5750 Reline complete maxillary denture (laboratory)
- D5751 Reline complete mandibular denture (laboratory)
- D5760 Reline maxillary partial denture (laboratory)
- D5761 Reline mandibular partial denture (laboratory)

Other Fixed Partial Denture Service

- D6930 Recement or rebond fixed partial denture

Extractions

- D7111 Extraction, coronal remnants - deciduous tooth
- D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Surgical Extractions

- D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
- D7220 Removal of impacted tooth - soft tissue
- D7230 Removal of impacted tooth - partially bony
- D7240 Removal of impacted tooth - completely bony
- D7241 Removal of impacted tooth - completely bony with unusual surgical complications
- D7250 Surgical removal of residual tooth roots (cutting procedure)
- D7251 Coronectomy - intentional partial tooth removal - only in conjunction with impacted tooth.

Other Surgical Procedures

- D7260 Oroantral fistula closure
- D7261 Primary closure of a sinus perforation
- D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
- D7280 Surgical access of an unerupted tooth
- D7282 Mobilization of erupted or malpositioned tooth to aid eruption
- D7283 Placement of device to facilitate eruption of impacted tooth

Alveoloplasty - Surgical Preparation of Ridge for Dentures

- D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
- D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
- D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
- D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant

Vestibuloplasty

- D7340 Vestibuloplasty - ridge extension (secondary epithelialization)
- D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)

Surgical Excision of Reactive Inflammatory Lesions

- D7410 Excision of benign lesion up to 1.25 cm

Removal of Tumors, Cysts, and Neoplasms

- D7411 Excision of benign lesion up to 1.25 cm
- D7412 Excision of benign lesion, complicated
- D7413 Excision of malignant lesion up to 1.25 cm
- D7414 Excision of malignant lesion greater than 1.25 cm
- D7415 Excision of malignant lesion, complicated
- D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm
- D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm
- D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm
- D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
- D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
- D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
- D7465 Destruction of lesion(s) by physical or chemical method, by report

Excision of Bone Tissue

- D7471 Removal of lateral exostosis (maxilla or mandible)
- D7472 Removal of torus palatinus
- D7473 Removal of torus mandibularis
- D7480 Partial ostectomy (guttering or saccerization)
- D7485 Surgical reduction of osseous tuberosity
- D7490 Radical resection of maxilla or mandible
- D7972 Surgical reduction of fibrous tuberosity

Surgical Incision

- D7510 Incision and drainage of abscess - intraoral soft tissue
- D7511 Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
- D7520 Incision and drainage of abscess - extraoral soft tissue
- D7521 Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
- D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
- D7540 Removal of reaction-producing foreign bodies - musculoskeletal system
- D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone
- D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body

Repair and Suturing

- D7910 Suture of recent small wound up to 5 cm
- D7911 Complicated suture - up to 5 cm
- D7912 Complicated suture - greater than 5 cm

Other Repair Procedures

- D7921 Collection and application of autologous blood concentrate product
- D7951 Sinus augmentation with bone or bone substitutes (Alternate Benefit may apply)
- D7952 Sinus augmentation via a vertical approach
- D7960 Frenulectomy (frenectomy or frenotomy) - separate procedure
- D7963 Frenuloplasty
- D7970 Excision of hyperplastic tissue - per arch
- D7971 Excision of pericoronal gingiva
- D7980 Sialolithotomy
- D7983 Closure of salivary fistula

Anesthesia

- D9210 Local anesthesia not in conjunction with restorative or surgical procedures
- D9211 Regional block anesthesia (only with restorative or surgical procedures)
- D9215 Local anesthesia (only with restorative or surgical procedures)
- D9219 Evaluation for deep sedation or general anesthesia
- D9220 Deep sedation/general anesthesia - first 30 minutes when Medically Necessary
- D9221 Deep sedation/general anesthesia - each additional 15 minutes when Medically Necessary
- D9241 Intravenous moderate (conscious) sedation/analgesia - first 30 minutes when Medically Necessary
- D9242 Intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes when Medically Necessary
- D9248 Non-intravenous moderate (conscious) sedation when Medically Necessary

Drugs

- D9610 Therapeutic parenteral drug, single administration
- D9630 Other drugs and /or medicaments, by report

Miscellaneous Services

- D9930 Treatment of complications (post-surgical) - unusual circumstances, by report
- D9931 Cleaning and inspection of a removable appliance

COVERED EXPENSES - MAJOR SERVICES

Major Restorative Dentistry – Inlay/onlay, crowns and other restorative services are covered only when necessitated by decay or traumatic Injury. The Alternate Benefit of a filling may be applied if there is not evidence to support major decay or traumatic Injury. Replacement of these services is limited to once every five years. This limitation is not applicable if treatment is the result of Accidental Dental Injury. Alternate Benefit of a prefabricated (temporary) crown is allowed for all Covered Persons under age 12.

Restorations (including polishing) – multiple restorations on one surface will be considered as a single restoration

- D2410 Gold foil – one surface (Alternate Benefit will apply)
- D2420 Gold foil – two surfaces (Alternate Benefit will apply)
- D2430 Gold foil – three surfaces (Alternate Benefit will apply)

Inlay/Onlay Restorations

- D2510 Inlay - metallic - one surface
- D2520 Inlay - metallic - two surfaces
- D2530 Inlay - metallic - three or more surfaces
- D2542 Onlay - metallic - two surfaces
- D2543 Onlay - metallic - three surfaces
- D2544 Onlay - metallic - four or more surfaces
- D2610 Inlay - porcelain/ceramic - one surface (Alternate Benefit may apply)
- D2620 Inlay - porcelain/ceramic - two surfaces (Alternate Benefit may apply)
- D2630 Inlay - porcelain/ceramic - three or more surfaces (Alternate Benefit may apply)
- D2642 Onlay - porcelain/ceramic - two surfaces (Alternate Benefit may apply)
- D2643 Onlay - porcelain/ceramic - three surfaces (Alternate Benefit may apply)
- D2644 Onlay - porcelain/ceramic - four or more surfaces (Alternate Benefit may apply)
- D2650 Inlay - resin-based composite - one surface
- D2651 Inlay - resin-based composite - two surfaces
- D2652 Inlay - resin-based composite - three or more surfaces
- D2662 Onlay - resin-based composite - two surfaces (Alternate Benefit may apply)
- D2663 Onlay - resin-based composite - three surfaces (Alternate Benefit may apply)
- D2664 Onlay - resin-based composite - four or more surfaces (Alternate Benefit may apply)

Crowns

- D2710 Crown - resin-based composite (indirect)
- D2712 Crown ³/₄ resin-based composite (indirect)
- D2720 Crown - resin with high noble metal (Alternate Benefit may apply)
- D2721 Crown - resin with predominantly base metal (Alternate Benefit may apply)
- D2722 Crown - resin with noble metal (Alternate Benefit may apply)
- D2740 Crown - porcelain/ceramic substrate (Alternate Benefit may apply)
- D2750 Crown - porcelain fused to high noble metal (Alternate Benefit may apply)
- D2751 Crown - porcelain fused to predominantly base metal (Alternate Benefit may apply)
- D2752 Crown - porcelain fused to noble metal (Alternate Benefit may apply)
- D2780 Crown - ³/₄ cast high noble metal
- D2781 Crown - ³/₄ cast predominantly base metal
- D2782 Crown - ³/₄ cast noble metal
- D2783 Crown - ³/₄ porcelain/ceramic
- D2790 Crown - full cast high noble metal
- D2791 Crown - full cast predominantly base metal
- D2792 Crown - full cast noble metal
- D2794 Crown – titanium
- D2799 Provisional crown – further treatment or completion of diagnosis necessary prior to final impression

- D2930 Prefabricated stainless steel crown-primary tooth
- D2931 Prefabricated stainless steel crown-permanent tooth
- D2932 Prefabricated resin crown
- D2933 Prefabricated stainless steel crown with resin window
- D2934 Prefabricated esthetic coated stainless steel crown-primary tooth

Other Restorative Services

- D2910 Recement or rebond inlay, onlay, veneer or partial coverage restoration
- D2915 Recement or rebond indirectly fabricated or prefabricated post and core
- D2920 Recement or rebond crown
- D2929 Prefabricated porcelain/ceramic crown--primary tooth
- D2940 Protective restoration
- D2950 Core buildup, including any pins
- D2951 Pin retention – per tooth, in addition to restoration
- D2952 Post and core in addition to crown, indirectly fabricated
- D2953 Each additional indirectly fabricated post - same tooth
- D2954 Prefabricated post and core in addition to crown
- D2957 Each additional prefabricated post - same tooth
- D2960 Labial veneer (laminare) - chairside
- D2961 Labial veneer (resin laminare) - laboratory
- D2962 Labial veneer (porcelain laminare) - laboratory
- D2971 Additional procedures to construct new crown under existing partial denture framework
- D2975 Coping
- D2980 Crown repair, necessitated by restorative material failure, by report
- D2981 Inlay repair necessitated by restorative material failure
- D2982 Onlay repair necessitated by restorative material failure
- D2983 Veneer repair necessitated by restorative material failure
- D2990 Resin infiltration of incipient smooth surface lesions

Dentures and Partials - Covered charges for dentures and partial dentures includes temporary appliances within 12 months of installation, and adjustments and relines within six months after installation. Specialized techniques and characterizations are not covered. Benefit limited to space maintainers for all Covered Persons under age 16. Replacement of these services is limited to once every five years. This limitation is not applicable if treatment is the result of Accidental Dental Injury. Alternate Benefit may apply if necessary replacement done within five years of the previous appliance.

Complete Dentures

- D5110 Complete denture - maxillary
- D5120 Complete denture - mandibular
- D5130 Immediate denture - maxillary
- D5140 Immediate denture - mandibular

Partial Dentures (including any conventional clasps, rests and teeth)

- D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)
- D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)
- D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
- D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
- D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth)
- D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth)
- D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth)

Repairs to Complete Dentures – Separate benefits are only after six months following installations of denture

- D5510 Repair broken complete denture base
- D5520 Replace missing or broken tooth – complete denture (each tooth)

Repairs to Partial Dentures

- D5610 Repair resin denture base
- D5620 Repair cast framework
- D5630 Repair or replace broken clasp
- D5640 Replace broken teeth – per tooth
- D5650 Add tooth to existing partial denture
- D5660 Add clasp to existing partial denture

Other Prosthodontic Services

- D5670 Replace all teeth and acrylic on cast metal framework (maxillary)
- D5671 Replace all teeth and acrylic on cast metal framework (mandibular)
- D5810 Interim complete denture, maxillary
- D5811 Interim complete denture, mandibular
- D5820 Interim partial denture, maxillary
- D5821 Interim partial denture, mandibular
- D5850 Tissue conditioning, maxillary
- D5851 Tissue conditioning, mandibular
- D5860 Overdenture - complete, by report (Alternate Benefit will apply)
- D5861 Overdenture - partial, by report (Alternate Benefit will apply)
- D6985 Pediatric partial denture, fixed (Alternate Benefit will apply)

Implant Services: Replacement of implant, abutment, retainer or denture is limited to once every five years. If more than one implant is performed in the same arch, the Alternate Benefit of a bridge or partial may be allowed. Alternate Benefit of a space maintainer or prefabricated (temporary) crown is allowed for all Covered Persons under age 16.

- D6010 Surgical placement of implant body: endosteal implant (Alternate Benefit may apply)
- D6012 Surgical placement of interim implant body for transitional prosthesis: endosteal implant (Alternate Benefit may apply)
- D6040 Surgical placement: eposteal implant (Alternate Benefit may apply)
- D6050 Surgical placement: transosteal implant (Alternate Benefit may apply)
- D6055 Dental implant supported connecting bar (Alternate Benefit may apply)
- D6056 Prefabricated abutment - includes placement (Alternate Benefit may apply)
- D6057 Custom fabricated abutment - includes placement (Alternate Benefit may apply)
- D6058 Abutment supported porcelain/ceramic crown (Alternate Benefit may apply)
- D6059 Abutment supported porcelain fused to metal crown (high noble metal) (Alternate Benefit may apply)
- D6060 Abutment supported porcelain fused to metal crown (predominantly base metal) (Alternate Benefit may apply)
- D6061 Abutment supported porcelain fused to metal crown (noble metal) (Alternate Benefit may apply)
- D6062 Abutment supported cast metal crown (high noble metal) (Alternate Benefit may apply)
- D6063 Abutment supported cast metal crown (predominantly base metal) (Alternate Benefit may apply)
- D6064 Abutment supported cast metal crown (noble metal) (Alternate Benefit may apply)

D6065 Implant supported porcelain/ceramic crown (Alternate Benefit may apply)
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal) (Alternate Benefit may apply)
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal) (Alternate Benefit may apply)
D6068 Abutment supported retainer for porcelain/ceramic FPD (Alternate Benefit may apply)
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal) (Alternate Benefit may apply)
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) (Alternate Benefit may apply)
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal) (Alternate Benefit may apply)
D6072 Abutment supported retainer for cast metal FPD (high noble metal) (Alternate Benefit may apply)
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal) (Alternate Benefit may apply)
D6074 Abutment supported retainer for cast metal FPD (noble metal) (Alternate Benefit may apply)
D6075 Implant supported retainer for ceramic FPD (Alternate Benefit may apply)
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal) (Alternate Benefit may apply)
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal) (Alternate Benefit may apply)
D6094 Abutment support crown - (titanium)
D6194 Abutment supported retainer crown for FPD - (titanium)
D7295 Harvest of bone for use in autogenous grafting procedure - per site
D7953 Bone replacement graft for ridge preservation - per site

Other Implant Services

D6051 Interim abutment
D6080 Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis
D6090 Repair implant supported prosthesis, by report
D6095 Repair implant abutment, by report
D6100 Implant removal, by report
D6101 Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure
D6102 Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure
D6103 Bone graft for repair of periimplant defect – not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration
D6104 Bone graft at time of implant placement
D6110 Implant / abutment-supported removable denture for edentulous arch – maxillary
D6111 Implant / abutment-supported removable denture for edentulous arch – mandibular
D6112 Implant / abutment-supported removable denture for partially edentulous arch – maxillary
D6113 Implant / abutment-supported removable denture for partially edentulous arch – mandibular
D6114 Implant / abutment-supported fixed denture for edentulous arch – maxillary
D6115 Implant / abutment-supported fixed denture for edentulous arch – mandibular
D6116 Implant / abutment-supported fixed denture for partially edentulous arch – maxillary
D6117 Implant / abutment-supported fixed denture for partially edentulous arch – mandibular
D6190 Radiographic/surgical implant index, by report

Fixed Partial Denture Pontics - Replacement of fixed partial dentures is limited to once every five years. This limitation is not applicable if treatment is the result of Accidental Dental Injury. If two or more teeth are missing in the same arch or two or more bridges are being performed in the same arch, an Alternate Benefit of a partial denture may be applied. Alternate Benefit applies and is limited to space maintainers for all Covered Persons under age 16.

- D6205 Pontic - indirect resin based composite (Alternate Benefit may apply)
- D6210 Pontic - cast high noble metal (Alternate Benefit may apply)
- D6211 Pontic - cast predominantly base metal (Alternate Benefit may apply)
- D6212 Pontic - cast noble metal (Alternate Benefit may apply)
- D6214 Pontic - titanium (Alternate Benefit may apply)
- D6240 Pontic - porcelain fused to high noble metal (Alternate Benefit may apply)
- D6241 Pontic - porcelain fused to predominantly base metal (Alternate Benefit may apply)
- D6242 Pontic - porcelain fused to noble metal (Alternate Benefit may apply)
- D6245 Pontic - porcelain/ceramic (Alternate Benefit may apply)
- D6250 Pontic - resin with high noble metal (Alternate Benefit may apply)
- D6251 Pontic - resin with predominantly base metal (Alternate Benefit may apply)
- D6252 Pontic - resin with noble metal (Alternate Benefit may apply)
- D6253 Provisional pontic – further treatment or completion of diagnosis necessary prior to final impression

Fixed Partial Denture Retainers - Replacement of fixed partial dentures is limited to once every five years. This limitation is not applicable if treatment is the result of Accidental Dental Injury. If two or more teeth are missing in the same arch or two or more bridges are being performed in the same arch, an Alternate Benefit of a partial denture may be applied. Alternate Benefit applies and is limited to a prefabricated (temporary) crown allowed for all Covered Persons under age 16.

- D6545 Retainer - cast metal for resin bonded fixed prosthesis
- D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis
- D6549 Resin retainer - for resin-bonded fixed prosthesis
- D6600 Inlay - porcelain/ceramic, two surfaces (Alternate Benefit may apply)
- D6601 Inlay - porcelain/ceramic, three or more surfaces (Alternate Benefit may apply)
- D6602 Inlay - cast high noble metal, two surfaces
- D6603 Inlay - cast high noble metal, three or more surfaces
- D6604 Inlay - cast predominantly base metal, two surfaces
- D6605 Inlay - cast predominantly base metal, three or more surfaces
- D6606 Inlay - cast noble metal, two surfaces
- D6607 Inlay - cast noble metal, three or more surfaces
- D6624 Inlay - titanium
- D6608 Onlay - porcelain/ceramic, two surfaces (Alternate Benefit may apply)
- D6609 Onlay - porcelain/ceramic, three or more surfaces (Alternate Benefit may apply)
- D6610 Onlay - cast high noble metal, two surfaces
- D6611 Onlay - cast high noble metal, three or more surfaces
- D6612 Onlay - cast predominantly base metal, two surfaces
- D6613 Onlay - cast predominantly base metal, three or more surfaces
- D6614 Onlay - cast noble metal, two surfaces
- D6615 Onlay - cast noble metal, three or more surfaces
- D6634 Onlay - titanium
- D6710 Crown - indirect resin based composite (Alternate Benefit may apply)
- D6720 Crown - resin with high noble metal (Alternate Benefit may apply)
- D6721 Crown - resin with predominantly base metal (Alternate Benefit may apply)
- D6722 Crown - resin with noble metal (Alternate Benefit may apply)
- D6740 Crown - porcelain/ceramic (Alternate Benefit may apply)
- D6750 Crown - porcelain fused to high noble metal (Alternate Benefit may apply)
- D6751 Crown - porcelain fused to predominantly base metal (Alternate Benefit may apply)
- D6752 Crown - porcelain fused to noble metal (Alternate Benefit may apply)

- D6780 Crown - 3/4 cast high noble metal
- D6781 Crown - 3/4 cast predominantly based metal
- D6782 Crown - 3/4 cast noble metal
- D6783 Crown - 3/4 porcelain/ceramic (Alternate Benefit may apply)
- D6790 Crown - full cast high noble metal
- D6791 Crown - full cast predominantly base metal
- D6792 Crown - full cast noble metal
- D6793 Provisional retainer crown – further treatment or completion of diagnosis necessary prior to final impression
- D6794 Crown - titanium

Other Fixed Partial Denture Services - Replacement of fixed partial dentures is limited to once every five years. This limitation is not applicable if treatment is the result of Accidental Dental Injury.

- D6940 Stress breaker (only with allowable appliance)
- D6980 Fixed partial denture repair, by report necessitated by restorative material failure
- D9120 Fixed partial denture sectioning

ORTHODONTIC BENEFITS PROVISION

The Plan will pay Covered Expenses for Orthodontic Procedures for the Covered Person. This benefit is subject to Medical Necessity and all other Plan provisions. Benefits are based on the Usual and Customary charge or the maximum fee schedule.

With respect to each Covered Person, the Lifetime Maximum Benefit payable under this Provision for all covered orthodontic expenses shall not exceed the Maximum Orthodontic Benefit shown in the Schedule of Benefits.

DEPENDENT CHILD LIMITATION

This provision shall apply only to an eligible Dependent Child who is age 19 or less on the date the Orthodontic Procedure begins. This Provision shall not apply to You or Your spouse. Benefits shall terminate under this provision for a Dependent Child on the date such Child turns age 19.

ORTHODONTIC PROCEDURE

Orthodontic Procedure means movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth. Orthodontic Procedure includes minor treatment to control harmful habits and diagnostic services (casts, consultation, exam, x-rays and related photos taken by the Dentist).

ORTHODONTIC TREATMENT PLAN

The Treatment Plan is a Dentist's report, on a form satisfactory to the Plan, which:

- Provides a classification of the malocclusion;
- Recommends and describes necessary treatment by Orthodontic Procedures;
- Estimates the duration over which treatment will be completed;
- Estimates the total charge for such treatment; and
- Is accompanied by cephalometric x-rays, study models and such other supporting evidence as the Plan may reasonably require.

COVERED ORTHODONTIC EXPENSES

To be payable, orthodontic treatment must be needed for one or more of the following conditions:

- Overbite or overjet of at least four millimeters; or
- Upper and lower arches in either protrusive or retrusive relation of at least one cusp; or
- Cross-bite; or
- An arch length difference of more than four millimeters in either the upper or lower arch.

COVERED EXPENSES - ORTHODONTIC

Clinical Oral Evaluations

- D0120 Periodic oral evaluation (performed in conjunction with orthodontic treatment)
- D0150 Comprehensive oral evaluation - new or established patient (performed in conjunction with orthodontic treatment)
- D0170 Reevaluation - limited, problem focused (established patient; not post-operative visit) (performed in conjunction with orthodontic treatment)
- D0180 Comprehensive periodontal evaluation - new or established patient (performed in conjunction with orthodontic treatment)

Radiographs/Diagnostic Imaging

- D0210 Intraoral - complete series (including bitewings) (performed in conjunction with orthodontic treatment)
- D0330 Panoramic radiographic image, including bitewings and periapicals if necessary (performed in conjunction with orthodontic treatment)
- D0340 Cephalometric radiographic image
- D0350 Oral/facial images (includes intra and extraoral images) (performed in conjunction with orthodontic treatment)

Tests and Laboratory Examinations

- D0470 Diagnostic casts (performed in conjunction with orthodontic treatment)

Other Surgical Procedures

- D7291 Transseptal fiberotomy, supra crestal fiberotomy, by report

Limited Orthodontic Treatment

- D8010 Limited orthodontic treatment of the primary dentition
- D8020 Limited orthodontic treatment of the transitional dentition
- D8030 Limited orthodontic treatment of the adolescent dentition
- D8040 Limited orthodontic treatment of the adult dentition

Interceptive Orthodontic Treatment

- D8050 Interceptive orthodontic treatment of the primary dentition
- D8060 Interceptive orthodontic treatment of the transitional dentition

Comprehensive Orthodontic Treatment

- D8070 Comprehensive orthodontic treatment of the transitional dentition
- D8080 Comprehensive orthodontic treatment of the adolescent dentition
- D8090 Comprehensive orthodontic treatment of the adult dentition

Minor Treatment To Control Harmful Habits

- D8210 Removable appliance therapy (performed in conjunction with orthodontic treatment)
- D8220 Fixed appliance therapy (performed in conjunction with orthodontic treatment)

Other Orthodontic Services

- D8660 Pre-orthodontic treatment, examination to monitor growth and development
- D8670 Periodic orthodontic treatment visit
- D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s))
- D8690 Orthodontic treatment (alternative billing to a contract fee)
- D8691 Repair of orthodontic appliance
- D8692 Replacement of lost or broken retainer (limited to replacement of broken retainer)
- D8693 Recement or rebond fixed retainers

COORDINATION OF BENEFITS

This Coordination of Benefits (COB) provision applies whenever a Covered Person has dental coverage under more than one Plan, as defined below. It does not, however, apply to prescription benefits. The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules below determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to total of 100% of charges Incurred may be paid between the plans.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group dental plans, whether insured or self-insured.
- Group health plans, whether insured or self-insured.
- Specific disease policies.
- Foreign policies.
- Medical coverage related to dental care under group or individual automobile policies. See order of benefit determination.
- Medicare or other governmental benefits as permitted by law. See below. This does not include Medicaid.
- This Plan does not, however, coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule to use.

- The plan that has no coordination of benefits provision is considered primary.
- When medical payments related to dental care are available under motor vehicle insurance (including no-fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier.
- Where an individual is covered under one plan as a Dependent and another plan as an Employee, member or subscriber, the plan that covers the person as an Employee, member or subscriber (that is, other than as a Dependent) is considered primary. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan.

- The plan that covers a person as a Dependent (or beneficiary under ERISA) is generally secondary. The plan that covers a person as a Dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent (see continuation coverage below).
- If an individual is covered under a spouse's Plan and also under his or her parent's plan, the Primary Plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the Secondary Plan.
- If one or more plans cover the same person as a Dependent Child:
 - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:
 - The parents are married; or
 - The parents are not separated (whether or not they have been married); or
 - A court decree awards joint custody without specifying that one party has the responsibility to provide dental care coverage.
 - If both parents have the same birthday, the Plan that covered either of the parents longer is primary.
 - If the specific terms of a court decree state that one of the parents is responsible for the Child's dental care expenses or dental care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.
 - If the parents are not married and reside separately, or are divorced or legally separated the order of benefits is:
 - The plan of the custodial parent;
 - The plan of the spouse of the custodial parent;
 - The plan of the non-custodial parent; and then
 - The plan of the spouse of the non-custodial parent.
- Active or Inactive Employee: If an individual is covered under one policy as an active employee (or the dependent of an active employee), and is also covered under another policy as a retired or laid off employee (or the dependent of an active or laid off employee), the policy that covers the person as an active employee (or dependent of an active employee) will be primary. This rule does not apply if the rule in paragraph 3 (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.
- Continuation Coverage under COBRA or state law: If a person has elected continuation of coverage under COBRA or state law, and also has coverage under another plan, the continuation coverage is usually secondary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies.
- Longer or Shorter Length of Coverage: The plan that covered the person as an Employee, member, subscriber or retiree longer is primary.
- If an active Employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active Employee, member or subscriber is considered primary.
- If the above rules do not determine the Primary Plan, the Covered Expenses can be shared equally between the plans. This Plan will not pay more than it would have paid, had it been primary.

TRICARE

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET PROVISION

The Plan has a right to subrogation and reimbursement. References to "You" or "Your" in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive for that Illness or Injury. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers' Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable.
 - Providing any relevant information requested by the Plan.
 - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or Injuries.
 - Making court appearances.
 - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
 - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.
- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.
- By participating in and accepting benefits from the Plan, You agree that:
 - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
 - You and Your representative will be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts; and
 - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to Your own negligence.
- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits You receive for the Illness or Injury out of any settlement, judgment, or other recovery from any third party considered responsible; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.
- If any third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.
- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.
- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

GENERAL EXCLUSIONS

The Plan does not pay for expenses Incurred for the following, even if deemed to be Medically Necessary, unless otherwise stated below. The Plan does not apply exclusions based upon the source of the Injury to treatment listed in this SPD as covered dental benefits when the Plan has information that the Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **Acts of War:** Illness or Injury caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.
2. **Appointments Missed:** An appointment the Covered Person did not attend.
3. **Athletic Mouth Guards.**
4. **Before Effective Date and After Termination:** Services, supplies or expenses Incurred before coverage begins under this Plan, or after coverage ends are not covered.
5. **Congenital:** Care of a congenital or developmental malformation including congenitally missing teeth.
6. **Cosmetic:** Services or treatment for cosmetic purposes as determined by the Plan, including but not limited to bleaching. This does not apply to Accidental Dental Injury or to orthodontic services.
7. **Criminal Activity:** Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony. The Plan shall enforce this exclusion based upon reasonable information showing that this criminal activity took place.
8. **Denture Duplication.**
9. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical or dental reports and itemized bills.
10. **Excess Charges:** Charges or the portion thereof which are in excess of the Usual and Customary charge, the Negotiated Rate or fee schedule.
11. **Experimental, Investigational or Unproven:** Services, supplies, medicines, treatment, facilities or equipment which the Plan determines are Experimental, Investigational or Unproven, including administrative services associated with Experimental, Investigational or Unproven treatments.
12. **Fractures:** treatment of fractures but not including teeth or alveolar process.
13. **Interest and Legal Fees.**
14. **Medications,** whether prescription or over-the-counter, other than those administered while in the Dentist's office as part of treatment.
15. **Military:** A military related Illness or Injury to a Covered Person on active military duty, unless payment is legally required.
16. **Multiple surgical** and periodontal procedures in the same area. Benefits will be limited to the most extensive and inclusive procedure.
17. **Myofunctional Therapy.**

18. **No-Fault State:** Benefits are not payable under this Plan for any Injury received in an accident involving a car or other motor vehicle for participants who are residents of a no-fault state and eligible for benefits under the no-fault motor vehicle law, until such time as the benefits under no-fault have been exhausted.
19. **Not Medically Necessary:** Services, supplies, treatment, facilities or equipment which the Plan determines are not Medically Necessary.
20. **Orthodontic Service** unless provided elsewhere in this document.
21. **Orthognathic Surgery** unless provided elsewhere in this document.
22. **Professionally Recognized Standards:** Procedures that are not necessary and do not meet professionally recognized standards of care.
23. **Programs** for oral hygiene or plaque control.
24. **Replacement** of lost, missing or stolen appliances regardless of any other provision of this Plan.
25. **Self-Inflicted** unless due to a medical condition (physical or mental) or domestic violence.
26. **Services At No Charge or Cost:** Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, or which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense code, or as required by law.
27. **Services Provided by a Close Relative.** See Glossary of Terms of this SPD for definition of Close Relative.
28. A **service** not furnished by a Dentist or Dental Hygienist who is acting under a Dentist's supervision and direction, unless it is for an x-ray ordered by a Dentist.
29. **Supplies** for plaque control or oral hygiene that can be purchased over-the-counter.
30. **Treatment** for the purpose of altering vertical dimension, restoring occlusion, splinting or replacing tooth structure lost as a result of abrasion, attrition or erosion, unless covered elsewhere in this document.
31. **Treatment of Disturbances** of the temporomandibular joint, craniomandibular disfunctions, myofacial pain syndrome, or any other disorder of the joint linking the jaw to the skull and the associated muscles. This exclusion also pertains / does not pertain to temporomandibular joint radiographs.
32. **Worker's Compensation:** An Illness or Injury arising out of or in the course of any employment for wage or profit, including self-employment for which the Covered Person was or could have been entitled to benefits under any Worker's Compensation, U.S. Longshoremen and Harbor Worker's or other occupational disease legislation, policy or contract, whether or not such policy or contract is actually in force.
33. **Benefits not specifically included in the Covered Expenses section of this document are considered excluded.**

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that benefit claims determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who may contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: the name of the Personal Representative, the date and duration of the appointment, and any other pertinent information. In addition, the Covered Person must agree to grant his or her Personal Representative access to his or her Protected Health Information. The Covered Person should contact the Claims Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, then the Covered Person will need to send the claim to the Plan within the timelines discussed below in order to receive reimbursement. The address for submitting dental claims is on the back of the group dental identification card.

Covered Persons who receive services in a country other than the United States are responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse Covered Persons for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person/patient ID number, name, sex, date of birth, Social Security number, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient account number (if applicable)
- Total billed charges
- Provider billing name, address, telephone number
- Provider Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)

- Whether the patient's condition is related to employment, auto accident, or other accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. Where Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veteran's Administration hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the timely filing period will not be allowed.

HOW DENTAL BENEFITS ARE CALCULATED

When UMR receives a claim for services that have been provided to a Covered Person, it will determine if the service is a covered benefit under this group dental Plan. If it is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If it is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to an established fee schedule, a Negotiated Rate for certain services, or as a percentage of the Usual and Customary fees.

Fee Schedule: Generally, providers are paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Plan Participation rate or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's allowable charge used in the calculation of the payable benefit.

Negotiated Rate: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service. The Negotiated Rate is what the Plan will pay to the provider, minus any Deductible, Plan Participation rate or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's Negotiated Rate.

Usual and Customary (U&C) is the amount that is usually charged by dental care providers in the same geographical area (or greater area, if necessary) for the same services, treatment or materials. An industry fee file is used to determine U&C fee allowances. The U&C level is at the 90th percentile. As it relates to charges made by a network provider, the term Usual and Customary means the Negotiated Rate as contractually agreed to by the provider and network (see above).

NOTIFICATION OF BENEFIT DETERMINATION

Each time a claim is submitted by a Covered Person or a provider on behalf of a Covered Person, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears correct. For any questions or concerns about the EOB form, call the Plan at the number listed on the EOB or on the back of the group dental identification card. The provider will receive a similar form on each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied for any of the following reasons:

- Termination of Your employment.
- Covered Person is no longer eligible for coverage under the dental Plan.
- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group dental Plan.
- Termination of the group dental Plan.
- Employee, Dependent or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations or penalties.
- Application of the Usual and Customary fee limits, fee schedule or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his or her Personal Representative may request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before any outside action is taken.

- The Covered Person must file the appeal within 180 days of the date he or she received the EOB form from the Plan showing that the claim was denied. The Plan will assume that the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- Covered Persons or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Covered Persons may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based in whole or in part on a dental judgment, the Plan will consult with a dental care professional with training and experience in the relevant dental field. This dental care professional may not have been involved in the original denial decision, nor be supervised by the dental care professional who was involved. If the Plan has obtained dental or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, Covered Persons will receive written notification letting them know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to You. The notification will provide Covered Persons with the information outlined under the Adverse Benefit Determination section above. It will also notify them of their right to file suit under ERISA after they have completed all mandatory appeal levels described in this SPD.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- Covered Persons who are not satisfied with the decision following the first appeal have the right to appeal the denial a second time.
- The Covered Person or his or her Personal Representative must submit a written request for a second review within 60 calendar days following the date he or she received the Plan's decision regarding the first appeal. The Plan will assume that the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- Covered Persons may submit written comments, documents, records and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.

- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based in whole or in part on a dental judgment, the Plan will consult with a dental care professional with training and experience in the relevant dental field. This dental care professional may not have been involved in the original denial decision or first appeal, nor be supervised by the dental care professional who was involved. If the Plan has obtained dental or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting them know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to You. The notification will provide the Covered Person with the information outlined under the Adverse Benefit Determination section above. It will also notify them of their right to file suit under ERISA after they have completed all mandatory appeal levels described in this SPD.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on their rights to any other benefits under the Plan. For any questions regarding the voluntary level of appeal including applicable rules, a Covered Person's right to representation (Personal Representative) or other details, please contact the Plan. Refer to the ERISA Statement of Rights section of this SPD for details on a Covered Person's additional rights to challenge the benefit decision under section 502(a) of ERISA.

Appeals should be sent within the prescribed time period as stated above to the following address(es):

Send Dental appeals to:
 UMR
 CLAIMS APPEAL UNIT
 PO BOX 30546
 SALT LAKE CITY UT 84130-0546

TIME PERIODS FOR MAKING DECISION ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where we are unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

The timelines below will only apply to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

Post-Service Claim: Within a reasonable period of time but no later than 60 calendar days after the Plan receives the request for review.

RIGHT TO EXTERNAL REVIEW

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program applies only if the adverse benefit determination is based on:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven Services; or
- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if UMR or Your employer fails to respond to Your appeal within the time lines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR or Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request to the following address:

UMR
EXTERNAL REVIEW
APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include: (1) Your specific request for an external review; (2) the Employee's name, address, and member ID number; (3) Your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within four months of the date You receive the Adverse Benefit Determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a qualified expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or Your employer. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical or dental records;
- All other documents relied upon by UMR and/or Your employer in making a decision on the case; and
- All other information or evidence that You or Your physician has already submitted to UMR or Your employer.

If there is any information or evidence that was not previously provided and that You or Your physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or Your employer with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

LEGAL ACTIONS FOLLOWING APPEALS

After completing all mandatory appeal levels through this Plan, Covered Persons have the right to further appeal Adverse Benefit Determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the ERISA Statement of Rights section of this SPD for more details.

No such action may be filed against the Plan after three years from the date the Plan gives the Covered Person a final determination on their appeal.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (i.e., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else, such as Your spouse or other family member - files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on his or her knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek dental treatment under his or her identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. He or she should answer all questions to the best of his or her knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, Your employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided that the following conditions are met:

- Contribution is paid; and
- The Employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal Family and Medical Leave Act of 1993 and any amendment; or
- The leave period required by applicable state law.

An Employee can choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant; and
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient); and
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy of the written procedures, at no charge, that the Plan uses when administering Qualified Medical Child Support Orders.

This group dental Plan also complies with the provisions of the:

- Coverage of Dependent Children in cases of adoption or Placement for Adoption as required by ERISA.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- The Genetic Information Nondiscrimination Act (GINA).

HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan shall disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care or Health Care Operations.

The Plan Sponsor shall use and/or disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care or Health Care Operations which it performs on behalf of this Plan.

This Plan agrees that it will only disclose a Covered Person's PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will only use and disclose a Covered Person's PHI (including Electronic PHI) for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;
- The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;
- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI to agree to implement reasonable and appropriate security measures to protect Electronic PHI;
- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;
- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;
- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not Use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;
- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;
- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;
- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Covered Persons have a right to see the disclosure log. The Plan Sponsor does not have to maintain a log if disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;
- The Plan Sponsor will make its internal practices, books and records relating to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;
- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;
- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of plan administration; and
- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan administrative functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Vice President of Human Resources, Human Resources Specialist, Human Resources Administrator, Chief Financial Officer, Vice President of Accounting & Financial Operations, Director Payroll & Benefits Accounting, Payroll & Benefits Accountant, Payroll Specialist and President & CEO

This list includes every Employee, class of Employees or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a BA is a person to whom the CE discloses protected health information (PHI) so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical or dental records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical (or dental) review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present or future physical or mental health or condition of a Covered Person, the provision of health care or the past, present or future Payment for the provision of health care; and
- Identifies the Covered Person or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Sponsor means Your employer.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing and monitoring.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

STATEMENT OF ERISA RIGHTS

Under the Employee Retirement Income Security Act of 1974 (ERISA), all Covered Persons shall have the right to:

RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as at work sites) all documents governing the Plan, including insurance contracts, collective bargaining agreements if applicable, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. No charge will be made for examining the documents at the Plan Administrator's principal office.
- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

CONTINUE GROUP DENTAL COVERAGE

Covered Persons have the right to continue dental care coverage if there is a loss of coverage under the Plan as a result of a COBRA qualifying event. You or Your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "Fiduciaries" of this Plan, have a duty to do so prudently and in the interest of all Plan participants.

NO DISCRIMINATION

No one may terminate Your employment or otherwise discriminate against You or Your covered Dependents in any way to prevent You or Your Dependents from obtaining a benefit or exercising rights provided to Covered Persons under ERISA.

ENFORCING COVERED PERSONS' RIGHTS

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

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, if a Covered Person requests a copy of the Plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, the Covered Person may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to \$110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a claim for benefits is denied or ignored, in whole or in part, the Covered Person may file suit in a state or federal court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical Child support order, the Covered Person may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money or if a Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees (for example, if it finds the claim to be frivolous).

ASSISTANCE WITH QUESTIONS

If there are any questions about this Plan, contact the Plan Administrator. For any questions about this statement or about a Covered Person's rights under ERISA, or for assistance in obtaining documents from the Plan Administrator, Covered Persons should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Covered Persons may also obtain certain publications about their rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, in the alternative, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy will be excluded from any benefit consideration.

The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Post tax contributions paid by COBRA beneficiaries and/or Retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the employer.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as a contract of employment between any Covered Person and the employer.

GLOSSARY OF TERMS

Accidental Dental Injury / Injury means damage to the mouth, teeth, and supporting tissues due directly to a blow from outside the mouth.

Adverse Benefit Determination means a denial, reduction or termination of a benefit or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Child (Children) means any of the following individuals with respect to an Employee: a natural biological Child; a step Child; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee or Spouse's permanent or temporary Legal Guardianship; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes You, Your spouse, mother, father, grandmother, grandfather, step parents, step grandparents, siblings, step siblings, half siblings, Children, step Children and grandchildren.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to a Qualifying Event.

Covered Expenses means any expense, or portion thereof, which is Incurred as a result of receiving an eligible benefit under this Plan.

Covered Person means an Employee or Dependent who is enrolled under this Plan.

Deductible is the amount of Covered Expenses which must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the individual and family Deductible (if any) and the dental care benefits to which it applies.

Dental Hygienist means a person who is licensed to practice dental hygiene and who works under the supervision and direction of a Dentist.

Dentist means a person who is licensed to practice dentistry, and who is practicing within the scope of such license. It shall also include any physician who furnishes any dental services which such physician is licensed to perform.

Dependent – see Eligibility and Enrollment section of this SPD.

Effective Date means the first day of coverage as defined in this SPD. The Covered Person's Effective Date may or may not be the same as their Enrollment Date, as Enrollment Date is defined in the Plan.

Emergency Dental Care means care of a dental condition which is required unexpectedly and immediately because of an Injury or Illness.

Employee – see Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the first day of the Waiting Period.
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the Enrollment Date is the first day coverage begins.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time and the applicable regulations.

Experimental, Investigational or Unproven means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;
- Items based on anecdotal and Unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered Experimental, Investigational or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

FMLA means the Family and Medical Leave Act of 1993, as amended.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information among other things.

Illness means a bodily disorder, disease, or physical sickness affecting the mouth, teeth or gums.

Incurred means the date the service or treatment is given, the supply is received or the facility is used, without regard to when the service, treatment, supply or facility is billed, charged or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer and who retains control over how the work gets done. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor shall be made consistent with Section § 530 of the Internal Revenue Code.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Legal Guardianship / Guardian means the individual is recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Maximum Benefit means the maximum amount or the maximum number of days or treatments that are considered a Covered Expense by the Plan.

Medically Necessary / Medical Necessity means treatment, services, supplies, medicines, or facilities necessary and appropriate for the diagnosis, care, or treatment of an Illness or Injury and which meet all of the following criteria as determined by the Plan:

- The health intervention is for the purpose of treating a dental condition; and
- Is the most appropriate supply or level of service, considering potential benefits and harms to the patient; and
- Is known to be effective in improving dental outcomes. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, and finally by expert opinion; and
- Is cost effective for this condition, compared to alternative interventions, including no intervention. Cost effective does not necessarily mean the lowest price; and
- Not primarily for the convenience or preference of the Covered Person, his or her family or any provider; and
- It is not Experimental, Investigational, Cosmetic or Custodial in nature; and
- Is currently or at the time the charges were Incurred recognized as acceptable medical practice by the Plan.

The fact that a Dentist has performed, prescribed, recommended, ordered, or approved a service, Treatment Plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, Treatment Plan, supply, equipment or facility Medically Necessary.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act as amended.

Negotiated Rate means the amount that providers have contracted to accept a payment in full for Covered Expenses of the Plan.

Pediatric Dental Services means services provided to individuals under the age of 19.

Placed or Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means GENE B GLICK COMPANY INC Group Dental Benefit Plan.

Plan Year Maximum Benefit means the maximum amount of covered benefits payable during a Plan Year while a person is covered under this Plan. Once the Plan Year Maximum Benefit is met, no further covered benefits will be available for the remainder of that Plan Year.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means an employer who sponsors a group dental plan.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered and/or certified in accordance with the applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Third Party Administrator (TPA) is a service provider hired by the Plan to process dental claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled is determined by the Plan in its sole discretion and generally means:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is qualified by education, training or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.
- Diagnosis of one or more of the following conditions is not considered proof of Total Disability. Conditions are listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases - Clinical Modification manual (most recent revision) (ICD-CM) in the following categories:
 - Personality disorders, or
 - Sexual/gender identity disorders, or
 - Behavior and impulse control disorders, or
 - "V" codes.

Treatment Plan means the Dentist's report to the Plan which:

- Lists the dental care recommended by the Dentist for the Covered Person; and
- Shows the Dentist's normal fee for each dental procedure; and
- Includes pre-operative x-rays and all other diagnostic materials needed by the Plan; and
- Is prepared on a form acceptable to the Plan.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross section of accurate data.

Waiting Period means a period of time that must pass before an Employee or Dependent is eligible to enroll under the terms of this Plan.

You, Your means the Employee.