Summary Plan Description

Dental Benefit Plan

This dental plan is that of your employer. Blue Cross Blue Shield of North Dakota is serving only as the Claims Administrator.

Blue Cross Blue Shield of North Dakota is an independent licensee of the Blue Cross & Blue Shield Association

Noridian Mutual Insurance Company

MEMBER SERVICES

Questions?

Our Member Services staff is available to answer questions about your coverage –

Call Member Services:

Monday through Friday
8:00 a.m. - 4:30 p.m. CST

1-877-586-6222

Office Address and Hours:

You may visit our Home Office during normal business hours –

Monday through Friday
8:00 a.m. - 4:30 p.m. CST

Bismarck Service Center
1415 Mapleton Avenue
Bismarck, North Dakota 58503

Mailing Address:

You may write to us at the following address –

Bismarck Service Center
PO Box 2657
Bismarck, North Dakota 58502

Internet Address:

www.BCBSND.com

District Offices:

We invite you to contact our District Office closest to you –

Fargo District Office
4510 13th Avenue South
(701) 277-2232

Jamestown Office
300 2nd Avenue Northeast
Suite 132
(701) 251-3180

Bismarck District Office
1415 Mapleton Avenue
(701) 223-6348

Dickinson Office
1674 15th Street West, Suite D
(701) 225-8092

Grand Forks District Office
American Office Park
2810 19th Avenue South
(701) 795-5340

Devils Lake Office
425 College Drive South, Suite 13
(701) 662-8613

Minot District Office
1308 20th Avenue Southwest
(701) 858-5000

Williston Office
1137 2nd Avenue West, Suite 105
(701) 572-4535

Your employer has established a self-funded employee welfare benefit plan for Eligible Employees and their Eligible Dependents. The following Summary Plan Description is provided to you in accordance with the Employee Retirement Income Security Act of 1974. Every attempt has been made to provide concise and accurate information. This Summary Plan Description and the Service Agreement are the official benefit plan documents for the employee welfare benefit plan established by the Plan Administrator. In case of conflict between this Summary Plan Description and the Service Agreement, the provisions of the Service Agreement will control.

Although it is the intention of the Plan Administrator to continue the self-funded employee welfare benefit plan for an indefinite period of time, the Plan Administrator reserves the right, whether in an individual case or in general, to eliminate the Benefit Plan.

The Claims Administrator shall have full, final and complete discretion to construe and interpret the provisions of the Service Agreement, the Summary Plan Description and related documents, including doubtful or disputed terms and to determine all questions of eligibility; and to conduct any and all reviews of claims denied in whole or in part. The decision of the Claims Administrator shall be final, conclusive and binding upon all parties.

PLAN NAME

Trinity Health Group Health Insurance Plan

NAME AND ADDRESS OF EMPLOYER (PLAN SPONSOR)

Trinity Health
One Burdick Expressway West
Minot, North Dakota 58701

PLAN SPONSOR'S IRS EMPLOYER IDENTIFICATION NUMBER

45-0226558

PLAN NUMBER ASSIGNED BY THE PLAN SPONSOR

501

TYPE OF WELFARE PLAN

Health

TYPE OF ADMINISTRATION

This is a self-funded employee welfare benefit plan. This plan is funded by Trinity Health. It is not insured. The Claims Administrator does not underwrite, insure or assume liability for payment of Covered Services available under the Benefit Plan. The Claims Administrator does not assume any obligation to pay claims except from funds contributed.

NAME AND ADDRESS OF CLAIMS ADMINISTRATOR

Blue Cross Blue Shield of North Dakota (BCBSND)
4510 13th Avenue South
Fargo, North Dakota 58121

PLAN ADMINISTRATOR'S NAME, BUSINESS ADDRESS AND BUSINESS TELEPHONE NUMBER

Trinity Health
One Burdick Expressway West
PO Box 5020
Minot, North Dakota 58702
701-857-5191

NAME AND ADDRESS OF AGENT FOR SERVICE OF LEGAL PROCESS

Plan Administrator:

Trinity Health
One Burdick Expressway West
PO Box 5020
Minot, North Dakota 58702

Claims Administrator:

Daniel R. Conrad
Blue Cross Blue Shield of North Dakota
4510 13th Avenue South
Fargo, North Dakota 58121

Service of legal process may be made upon a Plan trustee or the Plan Administrator.

TITLE OF EMPLOYEES AUTHORIZED TO RECEIVE PROTECTED HEALTH INFORMATION

Director Business Office
HR Generalist
HR Benefits Supervisor
Vice President

This includes every employee, class of employees, or other workforce person under control of the Plan Sponsor who may receive the Member's Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Benefit Plan in the ordinary course of business. These identified individuals will have access to the Member's Protected Health Information only to perform the plan administrative functions the Plan Sponsor provides to the Benefit Plan. Such individuals will be subject to disciplinary action for any use or disclosure of the Member's Protected Health Information in breach or in violation of, or noncompliance with, the privacy provisions of the Benefit Plan. The Plan Sponsor shall promptly report any such breach, violation, or noncompliance to the Plan Administrator; will cooperate with the Plan Administrator to correct the breach, violation and noncompliance to impose appropriate disciplinary action on each employee or other workforce person causing the breach, violation, or noncompliance; and will mitigate any harmful effect of the breach, violation, or noncompliance on any Member whose privacy may have been compromised.

STATEMENT OF ELIGIBILITY TO RECEIVE BENEFITS

All active full-time employees working at least 20 hours per week are eligible for participation immediately upon employment. Applications must be completed in 30 days or less from the date of employment. Coverage is effective the 1st or the 16th of the month following date of employment. Employees that are not eligible but then become eligible must make applications within 30 days of eligibility, and coverage will become effective the 1st or the 16th of the month following eligibility date.

If two married employees work for Trinity Health and one spouse is covered under this plan as a dependent, they shall not be covered as an employee. If both parents are employed by Trinity Health, children will be covered as a dependent of one parent only.

Eligibility to receive benefits under the Benefit Plan is initially determined by the Plan Administrator. When an eligible employee meets the criteria for eligibility, an application must be completed. The Claims Administrator may review this initial determination and has full discretion to determine eligibility for benefits. The Claims Administrator's decision shall be final, conclusive and binding upon all parties.

DESCRIPTION OF BENEFITS

See the Schedule of Benefits and the Covered Services Sections. Refer to the Table of Contents for page numbers.

SOURCES OF PREMIUM CONTRIBUTIONS TO THE PLAN AND THE METHOD BY WHICH THE AMOUNT OF CONTRIBUTION IS CALCULATED

Trinity Health will pay a portion of the decided coverage for full-time staff. Trinity will pay a prorated percentage of desired coverage based on hours worked for the length of time they are employed on a part-time basis.

END OF THE YEAR DATE FOR PURPOSES OF MAINTAINING THE PLAN'S FISCAL RECORDS

December 31

DENTAL BENEFITS
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INTRODUCTION

Benefits described in this Benefit Plan are available to Members and cannot be transferred or assigned. Any attempt to transfer or assign the benefits of this Benefit Plan to ineligible persons will result in automatic termination of this Benefit Plan by the Claims Administrator.

The Subscriber will receive an Identification Card displaying the Benefit Plan Number and other information about this Benefit Plan. All Members share this Benefit Plan Number. Carry the Identification Card at all times. If the Identification Card is lost, contact the Claims Administrator to request a replacement. The Subscriber must not let anyone other than an Eligible Dependent use the Identification Card. If another person is allowed to utilize the Identification Card, the Member's coverage will be terminated.

Present your Identification Card to your Dentist to identify yourself as a Member. Participating Dentists will submit claims on your behalf. You will be notified in writing by the Claims Administrator of benefit payments made for Covered Services. Please review your Explanation of Benefits and advise the Claims Administrator if you were billed for services you did not receive.

If you receive services from a Dentist that will not submit claims on your behalf, you are responsible for the submission of a written notice of a Claim for Benefits of the services you received within 18 months after services were provided. The written notice must include information necessary for the Claims Administrator to determine benefits.

The Subscriber hereby expressly acknowledges and understands that Blue Cross Blue Shield of North Dakota is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Blue Cross Blue Shield of North Dakota to use the Blue Cross and Blue Shield Service Marks in the state of North Dakota, and that Blue Cross Blue Shield of North Dakota is not contracting as an agent of the Association. The Subscriber further acknowledges and agrees this Benefit Plan was not entered into based upon representations by any person or entity other than Blue Cross Blue Shield of North Dakota and that no person, entity, or organization other than Blue Cross Blue Shield of North Dakota shall be held accountable or liable to the Subscriber for any of Blue Cross Blue Shield of North Dakota's obligations to the Subscriber created under this Benefit Plan. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross Blue Shield of North Dakota other than those obligations created under other provisions of this Benefit Plan.

SECTION 1
SCHEDULE OF BENEFITS

This section outlines the payment provisions for Covered Services described in Section 2, subject to the definitions, exclusions, conditions and limitations of this Benefit Plan.

The Claims Administrator shall have full discretion to interpret and determine the application of the Schedule of Benefits in each and every situation. Any decisions by the Claims Administrator regarding the Schedule of Benefits shall be final, conclusive and binding upon all parties.

1.1 COST SHARING AMOUNTS

Cost Sharing Amounts include Coinsurance, Copayment and Deductible Amounts. A Member is responsible for the Cost Sharing Amounts. Please see Section 2, Covered Services, for the specific Cost Sharing Amounts that apply to this Benefit Plan. All Members contribute to the Deductible Amount. However, a Member's contribution cannot be more than the Single Participation amount. Participating Dentists may bill you directly or request payment of Coinsurance, Copayment and Deductible Amounts at the time services are provided.

Under this Benefit Plan the Deductible Amounts are:

Single Participation	$50 per Benefit Period
Family Participation	$100 per Benefit Period

1.2 BENEFIT MAXIMUM

Benefit Period Maximum is:

Covered Dental Services	$1,000 per Member per Benefit Period

1.3 SELECTING A DENTAL PROVIDER

This Benefit Plan recognizes the following categories of Dentists based on the Dentist's relationship with the Claims Administrator.

A. Participating Dentist

When Covered Services are received from a Participating Dentist, the Participating Dentist agrees to submit claims to the Claims Administrator on behalf of the Member. Reimbursement for Covered Services will be made directly to the Participating Dentist according to the terms of this Benefit Plan and the participation agreement between the Participating Dentist and the Claims Administrator.

When Covered Services are received from a Participating Dentist, a provider discount provision is in effect. This means the Allowance paid by the Claims Administrator will be considered by the Participating Dentist as payment in full, except for Cost Sharing Amounts, Maximum Benefit Allowances or Lifetime Maximums.

B. **Participating Dentists with the GRID Dental Program**

When Covered Services are received through the GRID Dental Program outside the geographic area the Claims Administrator serves, the amount the Member pays for Covered Services is calculated on the lower of the billed charges for Covered Services, or the negotiated price made available to the Claims Administrator by the GRID Dental Program. The Dentist agrees to submit claims to the Claims Administrator on behalf of the Member, and reimbursement will be made directly to the Dentist according to the terms of the Benefit Plan and the participation agreement between the Dentist and the GRID Dental Program. The amount paid by the Claims Administrator will be considered by the Dentist as payment in full, except for Cost Sharing Amounts, Maximum Benefit Allowances or Lifetime Maximums.

C. **Nonparticipating Dentist**

If a Member receives Covered Services from a Nonparticipating Dentist, the Member will be responsible for notifying the Claims Administrator of the receipt of services. If the Claims Administrator needs copies of dental records to process the Member's claim, the Member is responsible for obtaining such records from the Nonparticipating Dentist.

1. Nonparticipating Dentists Within the State of North Dakota

   If a Member receives Covered Services from a Nonparticipating Dentist within the state of North Dakota, benefit payments will be based on the Allowance and reduced by an additional 20%.

   The Member is responsible for the 20% payment reduction and any charges in excess of the Allowance for Covered Services.

   Benefit payment will be made directly to the Subscriber for Covered Services received from a Nonparticipating Dentist within North Dakota. The Claims Administrator will not honor an assignment of benefit payments to any other person or Dentist.

2. Nonparticipating Dentists Outside the State of North Dakota

   If a Member receives Covered Services from a Nonparticipating Dentist outside the state of North Dakota, the Allowance for Covered Services will be an amount within a general range of payments made and judged to be reasonable by the Claims Administrator.

   The Member is responsible for any charges in excess of the Allowance for Covered Services.

   If a Member receives Covered Services from a Dentist in a county contiguous to North Dakota, the benefit payment will be provided on the same basis as a Dentist located in the state of North Dakota. If the Dentist is a Participating Dentist, the benefit payment will be as indicated in Section 1.3 (A) and Section 2, Covered Services. If the Dentist is not a Participating Dentist, benefits will be available at the same level as Nonparticipating Dentists within the state of North Dakota.

   An assignment of payment to an out-of-state Dentist must be in writing, filed with and approved by the Claims Administrator.

The Member's dental care is between the Member and the Member's Dentist. The ultimate decision on the Member's dental care must be made by the Member and the Member's Dentist. The Claims Administrator only has the authority to determine the extent of benefits available for Covered Services under this Benefit Plan.

SECTION 2
COVERED SERVICES

This section describes the services for which benefits are available under this Benefit Plan subject to the definitions, exclusions, conditions and limitations of this Benefit Plan, Cost Sharing Amounts and Benefit Maximum as described in the Schedule of Benefits.

A Treatment Plan is recommended for services exceeding $1,500.

The services below are identified in accordance with categorizations established by The American Dental Association. Please retain this Benefit Plan and the Benefit Plan Attachment to determine Covered Services for this Dental Benefit Plan.

The Claims Administrator shall have full discretion to interpret and determine the application of the Covered Services in each and every situation. Any decisions by the Claims Administrator regarding the Covered Services shall be final, conclusive and binding upon all parties.

CATEGORY 1 **DIAGNOSTIC**

A. Routine oral evaluations allowed twice during a Benefit Period paid at 100% of Allowed Charge. Deductible Amount is waived.

B. Bitewing X-rays allowed once during a Benefit Period, except when part of a full mouth survey, paid at 100% of Allowed Charge. Deductible Amount is waived.

C. Full mouth survey allowed once every 3 years paid at 100% of Allowed Charge. Deductible Amount is waived.

D. Panoramic film allowed once every 3 years paid at 100% of Allowed Charge. Deductible Amount is waived.

E. Intraoral periapical X-rays paid at 100% of Allowed Charge. Deductible Amount is waived.

CATEGORY 2 **PREVENTIVE**

A. Prophylaxis allowed 4 times during a Benefit Period subject to a $10 Copayment Amount, then 100% of Allowed Charge. Deductible Amount is waived.

B. Topical Fluoride applications allowed twice during a Benefit Period paid at 100% of Allowed Charge. Deductible Amount is waived.

C. Sealants on unfilled, undecayed permanent molars and bicuspids provided for dependent children paid at 80% of Allowed Charge. Benefits are limited to a Lifetime Maximum of 2 sealants per tooth.

D. Space maintainers paid at 80% of Allowed Charge.

CATEGORY 3 **RESTORATIVE**

A. Fillings (pin-retention - limit 2) paid at 80% of Allowed Charge.

B. Inlays, onlays and Crowns (not part of a fixed partial Denture). Replacement of lost or defective inlays, onlays or Crowns is allowed once every 5 years paid at 50% of Allowed Charge.

C. Veneers other than cosmetic are allowed once every 5 years paid at 50% of Allowed Charge.

CATEGORY 4 **ENDODONTICS**

A. Pulpotomy, pulp capping, root canal therapy, apicoectomy, root amputation, hemisection, bleaching of endodontically treated anterior permanent teeth paid at 80% of Allowed Charge.

CATEGORY 5 **PERIODONTICS**

A. Surgical Periodontic evaluation once for each course of treatment paid at 80% of Allowed Charge.

B. Gingivectomy, Gingival Curettage, mucogingival surgery, osseous surgery paid at 80% of Allowed Charge.

C. Periodontal scaling and root planing paid at 80% of Allowed Charge.

CATEGORY 6 **PROSTHODONTICS** (removable)

A. Dentures (complete and partial). Replacement of lost or defective Dentures is allowed once every 5 years paid at 50% of Allowed Charge.

B. Tissue conditioning twice per treatment sequence for relining or for new or duplicate Dentures paid at 50% of Allowed Charge.

C. Relining of immediate Dentures once during the year after insertion paid at 50% of Allowed Charge.

D. Relining of complete and partial Dentures other than in item above, allowed once every 3 years paid at 50% of Allowed Charge.

E. Repair of Dentures paid at 50% of Allowed Charge.

CATEGORY 7 **MAXILLOFACIAL PROSTHETICS**

No benefits are available.

CATEGORY 8 **IMPLANT SERVICES**

A. Surgical implant procedures, including prosthetic restoration paid at 50% of Allowed Charge.

CATEGORY 9 **PROSTHODONTICS** (fixed)

A. Fixed partial Denture. Replacement of lost or defective fixed partial Dentures is allowed once every 5 years paid at 50% of Allowed Charge.

CATEGORY 10 **ORAL AND MAXILLOFACIAL SURGERY**

A. Simple extractions paid at 80% of Allowed Charge.

B. Surgical extractions paid at 80% of Allowed Charge.

C. Oral Maxillofacial Surgery including fracture and dislocation treatment, frenulectomy and cyst and abscess diagnosis and treatment paid at 50% of Allowed Charge.

CATEGORY 11 **ORTHODONTICS**

No benefits are available.

CATEGORY 12 **ADJUNCTIVE GENERAL SERVICES**

A. Palliative (emergency) treatment of dental pain paid at 100% of Allowed Charge. Deductible Amount is waived.

B. Anesthesia services paid at 80% of Allowed Charge.

C. Occlusal guard for treatment of Bruxism allowed once every 3 years paid at 50% of Allowed Charge.

If, during the course of treatment, a Member transfers from the care of one Dentist to another, or if more than one Dentist provides services for the same dental procedure, the Claims Administrator will only be liable for the amount it would have paid if only one Dentist had provided the service.

If there are alternative courses of treatment, the Claims Administrator will provide benefits for the most cost-effective treatment.

SECTION 3
EXCLUSIONS

No benefits are available for services listed in this section. The following list is not a complete list. In addition to these general exclusions, limitations and conditions there may be others that apply to specific Covered Services that can be found in the Covered Services section and elsewhere in this Benefit Plan. If a benefit or service is not covered, then all services, treatments, devices or supplies provided in conjunction with that benefit or service are not covered. Please read this section carefully before seeking services and submitting a Claim for Benefits. Please contact Member Services at the telephone number listed on the back of the Identification Card if you have any questions.

The Claims Administrator shall have full discretion to interpret and determine the application of the Exclusions in each and every situation. Any decisions by the Claims Administrator regarding the Exclusions shall be final, conclusive and binding upon all parties.

3.1 EXCLUSIONS

No benefits are available for:

1. Bacteriologic cultures for the determination of pathological agents.
2. Caries susceptibility tests.
3. Nutritional counseling for the control of dental disease, oral hygiene instruction and personal hygiene and convenience items.
4. Tobacco counseling for the control and prevention of oral disease.
5. Sealants on Deciduous teeth.
6. Surgical procedures for isolation of a tooth with a rubber dam.
7. Services for cosmetic reasons Including bleaching and veneers.
8. Replacement of prosthetic appliances.
9. Ridge augmentation.
10. Cleft palate therapy.
11. Replacement and/or repair of Orthodontic appliances.
12. General Anesthesia for routine procedures.
13. Consultations.
14. House calls.
15. Hospital calls.
16. Office visits either during or after regular scheduled office hours with no operative services performed.
17. Therapeutic drug injections.
18. Prescription medications or drugs or Medicaments.
19. Application of desensitizing Medicaments.

20. Occlusal adjustment (limited/complete).

21. Enamel microabrasion.

22. Treatment of temporomandibular (TMJ) or craniomandibular (CMJ) joint disorders.

23. Behavioral management.

24. Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicullar tissue.

25. Services not prescribed by or performed by or under the direct supervision of a Dentist and services that are beyond the Dentist's scope of licensure.

26. Services that in the sole discretion of the Claims Administrator are Experimental or Investigative.

27. Any services when benefits are provided by a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, similar person or group.

28. Surgery and related services primarily intended to improve appearance and not to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

29. Charges for failure to keep a scheduled appointment or charges for completion of any forms required by the Claims Administrator.

30. Appliances or restorations necessary to increase vertical dimensions or to restore an occlusion.

31. Services for which a Member incurs no charge.

32. Services that are received during a Waiting Period of 270 consecutive days, beginning on the effective date of the individual Member's coverage, excluding services for accidental services.

33. Claims for services that exceed the amount that would have been paid by the Subscriber if no coverage existed under this Benefit Plan.

34. Services provided to a Member prior to the effective date of Member's Benefit Plan. This includes dental services in progress before and concluded after the effective date of coverage if received as part of an original Treatment Plan.

35. Services when benefits are provided by any governmental unit or social agency, except for Medicaid or when payment has been made under Medicare Part A or Part B. Medicare Part A and Part B will be considered the primary payor with respect to benefit payments unless otherwise required by law.

36. Services considered inconsistent with accepted dental practices as determined by the Claims Administrator.

37. Illness or injury caused directly or indirectly by war or an act of war or sustained while performing military services, if benefits for such illness or injury are available under the laws of the United States or any political subdivision thereof.

38. Illness or bodily injury that arises out of and in the course of a Member's employment if benefits or compensation for such illness or injury are available under the provisions of a state workers' compensation act, the laws of the United States or any state or political subdivision thereof.

39. Loss caused or contributed by a Member's commission or attempted commission of a felony (except losses caused or contributed by an act of domestic violence or any health condition) or a Member's involvement in an illegal occupation following the Member's enrollment in this Benefit Plan.

40. Dental screening assessment programs or dental education services, Including all forms of communication media whether audio, visual or written.

41. Complications resulting from noncovered services received by the Member.

42. Services that a Member has no legal obligation to pay in the absence of this or any similar coverage.

43. Cost Sharing Amounts.

44. Services, treatments or supplies that are not specified as a Covered Service under this Benefit Plan.

SECTION 4
GENERAL PROVISIONS

The Claims Administrator shall have full discretion to interpret and determine the application of the General Provisions in each and every situation. Any decisions by the Claims Administrator regarding the General Provisions shall be final, conclusive and binding upon all parties.

4.1 STATUS OF MEMBER ELIGIBILITY

The Plan Administrator agrees to furnish the Claims Administrator with any information required by the Claims Administrator for the purpose of enrollment. Any changes affecting a Member's eligibility for coverage must be provided to the Claims Administrator by the Plan Administrator and/or the Member immediately, but in any event the Plan Administrator and/or the Member shall notify the Claims Administrator within 31 days of the change.

Statements made on applications are deemed representations and not warranties. No statements made on the application may be used in any contest unless a copy has been furnished to that person, or in the event of the death or incapacity of that person, to the individual's beneficiary or personal representative. The Subscriber is provided a copy of the application at the time of completion.

4.2 DENTAL EVALUATIONS

The Claims Administrator, at its own expense, may require a dental evaluation of the Member as often as necessary during the pendency of a Claim for Benefits.

4.3 LIMITATION OF ACTIONS

No legal action may be brought for payment of benefits under this Benefit Plan prior to the expiration of 60 days following the Claims Administrator's receipt of a Claim for Benefits or later than 3 years after the expiration of the time within which notice of a Claim for Benefits is required by this Benefit Plan.

4.4 PREMIUM REFUND/DEATH OF THE SUBSCRIBER

In the event of the Subscriber's death, the Claims Administrator will refund one-half month's premium if death occurred prior to the sixteenth of the month and all premiums paid beyond the month of the Subscriber's death, within 31 days after receiving notice of the death.

4.5 NOTIFICATION REQUIREMENTS AND SPECIAL ENROLLMENT PROVISIONS

A. The Subscriber is responsible for notifying the Plan Administrator and the Claims Administrator of any mailing address change within 31 days of the change.

B. The Subscriber is responsible for notifying the Plan Administrator and the Claims Administrator of any change in marital status within 31 days of the change.

1. If the Subscriber marries, Eligible Dependents may be added as a Member if an application is submitted within 31 days of the date of marriage. If the application is not submitted within the 31-day period, the Eligible Dependent may apply for coverage during the Annual Enrollment Period.

   If the application is submitted within 31 days of the date of marriage, the date of coverage for the Eligible Dependent will be the first of the month following the date of marriage. Dental benefits will not be available until the Waiting Period has been met, with the exception of accidental injury.

2. If, because of legal separation, divorce, annulment or death, the Subscriber's spouse is no longer eligible for coverage under this Benefit Plan, the Subscriber's spouse may be eligible for continued dental coverage. See Section 4.8.

Coverage for the Subscriber's spouse under Family Participation will cease effective the first of the month immediately following timely notice of legal separation, divorce or annulment.

C. The Subscriber is responsible for notifying the Plan Administrator and the Claims Administrator of any change in family status within 31 days of the change.

The effective date of coverage for dependents added to this Benefit Plan within the designated time period will be the first or the sixteenth of the month immediately preceding the date of birth, physical placement or court order. The following provisions will apply:

1. At the time of birth, natural children will automatically be added to the Subscriber's Benefit Plan if Family Participation is in force. If the Subscriber is enrolled under another Class of Participation, the Subscriber must submit an application for the newborn child within 31 days of the date of birth. If the application is not submitted within the designated time period, the child may apply for coverage during the Annual Enrollment Period. Dental benefits will not be available until the Waiting Period has been met, with the exception of accidental injury.

2. Adopted children may be added to this Benefit Plan if an application, accompanied by a copy of the placement agreement or court order, is submitted to the Claims Administrator within 31 days of physical placement of the child. If the application is not submitted within the designated time period, the child may apply for coverage during the Annual Enrollment Period. Dental benefits will not be available until the Waiting Period has been met, with the exception of accidental injury.

3. Children for whom the Subscriber or the Subscriber's living, covered spouse or domestic partner have been appointed legal guardian may be added to this Benefit Plan by submitting an application within 31 days of the date legal guardianship is established by court order. If the application is not submitted within the designated time period, the child may apply for coverage during the Annual Enrollment Period. Dental benefits will not be available until the Waiting Period has been met, with the exception of accidental injury.

4. Children for whom the Subscriber or the Subscriber's living, covered spouse or domestic partner are required by court order to provide dental benefits may be added to this Benefit Plan by submitting an application within 31 days of the date established by court order. If the application is not submitted within the designated time period, the child may apply for coverage during the Annual Enrollment Period. Dental benefits will not be available until the Waiting Period has been met, with the exception of accidental injury.

5. If any of the Subscriber's children beyond the age of 26 are medically certified as intellectually disabled or physically disabled, the Subscriber may continue their coverage under Family Participation. Coverage will remain in effect as long as the child remains disabled, unmarried and financially dependent on the Subscriber or the Subscriber's living, covered spouse or domestic partner. The Claims Administrator may request annual verification of a child's disability after coverage for a disabled child has been in effect for 2 years.

   The Subscriber must provide proof of incapacity and dependency of a child's disability within 31 days after the end of the month in which a child turns 26 or, if a child is beyond age 26, at the time of initial enrollment.

6. If a child is no longer an Eligible Dependent under this Benefit Plan, they may be eligible for continued dental coverage. See Section 4.8.

D. If an employee elects not to enroll at the time of initial eligibility, subsequent application can be made during the Annual Enrollment Period. Coverage will be effective on the Group's anniversary date.

E. Eligible Dependents added to this Benefit Plan during the Annual Enrollment Period [with the exception of 4.5 (C.)(1.), (2.), (3.) and (4.)] will be subject to a Waiting Period for all but accidental injury. Coverage will be effective on the Group's anniversary date.

F. Once a Subscriber has selected Family Participation, they may convert to Single Participation only upon a change in marital status, if the Subscriber's spouse obtains other employer group dental coverage or during the Annual Enrollment Period.

The conversion to Single Participation will be effective the first or the sixteenth of the month immediately following timely notice to the Group or Plan Administrator, if other than the Group, and the Claims Administrator of the change in marital status, the Subscriber's spouse's obtainment of other employer group dental coverage or during the Annual Enrollment Period.

G. If a Subscriber cancels dental coverage while still eligible, they may enroll again only after a minimum of 2 years has passed. An application must be submitted during the Annual Enrollment Period. Coverage will be effective on the Group's anniversary date. Dental benefits will not be available until the Waiting Period has been met, with the exception of accidental injury.

4.6 QUALIFIED MEDICAL CHILD SUPPORT ORDERS

This provision applies to Members affected by ERISA. See Section 4.9.

For the purpose of this provision, the term 'medical' is limited to the dental benefits provided under this plan.

This Benefit Plan shall provide benefits in accordance with the applicable requirements of a Qualified Medical Child Support Order (QMCSO) pursuant to the provisions of §609 of the Employee Retirement Income Security Act (ERISA) and §1908 of the Social Security Act and any other applicable laws.

The term "child" as used in this provision means any child of a Subscriber who is recognized under a medical child support order as having a right to enrollment under this Benefit Plan with respect to such Subscriber. In connection with any adoption, or placement for adoption, of the child, the term "child" means an individual who has not attained the age of 18 as of the date of such adoption or placement for adoption.

A. A Medical Child Support Order (MCSO) is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a child of a Subscriber under a group medical plan or provides for medical benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under such plan; or

2. Enforces a state law relating to medical child support described in §1908 of the Social Security Act with respect to a group medical plan.

B. A Qualified Medical Child Support Order is a Medical Child Support Order that:

1. Creates or recognizes the existence of a child's right to, or assigns to a child the right to, receive benefits for which a Subscriber or Member is eligible under the medical plan; and

2. Clearly specifies:

a. the name and last known mailing address (if any) of the Subscriber and the name and mailing address of each child covered by the order;

b. a reasonable description of the type of coverage to be provided by the plan to each such child, or the manner in which such type of coverage is to be determined;

c. the period to which such order applies; and

d. each plan to which such order applies.

A MCSO qualifies as a QMCSO only if such order does not require the plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of a law relating to dental child support described in §1908 of the Social Security Act.

C. The MCSO shall be submitted to the Plan Administrator for review. The Plan Administrator shall determine whether the MCSO qualifies as a QMCSO. The Plan Administrator shall promptly notify the Subscriber and each person specified in a MCSO as eligible to receive benefits under this Benefit Plan, (at the address included in the MCSO) of the receipt of the MCSO and the Plan Administrator's procedures for determining whether the MCSO is a QMCSO. Within 30 days or such other reasonable period after receipt of the MCSO, the Plan Administrator shall determine whether the MCSO is a QMCSO and notify the Subscriber and each child of such determination.

If the Plan Administrator determines that the MCSO qualifies as a QMCSO, the Plan Administrator shall immediately notify the Claims Administrator of that determination and of the name and mailing address of all children who are to be covered under this Benefit Plan. The Claims Administrator will forward all appropriate forms to each child for enrollment in this Benefit Plan. The forms must be completed by or on behalf of the child and returned to the Claims Administrator.

A child under a QMCSO shall be considered a Member under this Benefit Plan for purposes of any provision of ERISA. A child under any MCSO shall be considered a Subscriber of this Benefit Plan for purposes of the reporting and disclosure requirements of Part I of ERISA. A child may designate a representative for receipt of copies of notices that are sent to the child with respect to a MCSO.

Any payment for benefits made by this Benefit Plan pursuant to a MCSO in reimbursement for expenses paid by a child or a child's custodial parent or legal guardian shall be made to the child or the child's custodial parent or legal guardian.

4.7 MEDICAID ELIGIBILITY

This provision applies to Members affected by ERISA. See Section 4.9.

A. When enrolling an individual as a Member, or in determining or making any payment for benefits, this Benefit Plan will not take into account the fact the Member is eligible for or covered by Medicaid.

B. This Benefit Plan will make payment for benefits in accordance with any assignment of rights made by or on behalf of the Member.

C. If Medicaid covers a Member and Medicaid pays benefits that should have been paid by this Benefit Plan, this Benefit Plan will pay those benefits directly to Medicaid rather than to the Member.

4.8 CONTINUATION

A. Federal Continuation (COBRA)

This provision applies under amendments to the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, et seq. and the Public Health Service Act, 42 U.S.C. §300bb-1, et seq. These amendments are collectively referred to as "COBRA". COBRA provides for optional continuation coverage for certain Subscribers and/or Eligible Dependents under certain circumstances if the employer maintaining the group health plan normally employed 20 or more employees on a typical business day during the preceding calendar year. This provision is intended to comply with the law and any pertinent regulations and its interpretation is governed by them. This provision is not intended to provide any options or coverage beyond what is required by federal law. Subscribers should consult their Plan Administrator to find out if and how this provision applies to them and/or their Eligible Dependents.

A Subscriber covered by this Benefit Plan may have the right to choose continuation coverage if the Subscriber's group coverage is terminated because of a reduction in hours of employment or the termination of employment for reasons other than gross misconduct.

The spouse of the Subscriber covered by this Benefit Plan may have the right to choose continuation coverage if group coverage is terminated for any of the following reasons:

1. The death of the Subscriber;

2. A termination of the Subscriber's employment for reasons other than gross misconduct or a reduction in hours of employment;

3. Divorce or legal separation; or

4. The Subscriber becomes entitled to Medicare benefits.

A dependent child of the Subscriber covered by this Benefit Plan may have the right to continuation coverage if group coverage is terminated for any of the following reasons:

1. The death of the Subscriber;

2. The termination of the Subscriber's employment for reasons other than gross misconduct or reduction in a parent's hours of employment;

3. Parent's divorce or legal separation;

4. The Subscriber becomes entitled to Medicare; or

5. The dependent ceases to be an Eligible Dependent under this Benefit Plan.

A child who is born to a Subscriber or is placed for adoption with the Subscriber during the period of continuation coverage is eligible for COBRA coverage.

Continuation may apply in the event of a bankruptcy of the Group for certain retired Subscribers and their Eligible Dependents under certain conditions. If there is a bankruptcy of the Group, retired Subscribers and their Eligible Dependents should contact their Plan Administrator for more information.

The Subscriber or the Subscriber's Eligible Dependents have the responsibility to inform the Plan Administrator within 60 days of a divorce, legal separation or a child losing dependent status under this Benefit Plan. Where the Subscriber or an Eligible Dependent have been determined to be disabled under the Social Security Act, they must inform the Plan Administrator of such determination within 60 days after the date of the determination. The Subscriber or the Subscriber's Eligible Dependents are responsible for notifying the Plan Administrator within 30 days after the date of any final determination under the Social Security Act that the Subscriber or Eligible Dependent is no longer disabled.

When the Plan Administrator is notified that one of these events has occurred or has knowledge of the Subscriber's death, termination of employment, reduction in hours or Medicare entitlement, the Plan Administrator will notify the Subscriber or Eligible Dependents, as required by law of the right to choose continuation coverage. The Subscriber or Eligible Dependents has 60 days from the date coverage is lost, because of one of the events described above or 60 days from the date the Subscriber or Eligible Dependent is sent notice of his or her right to choose continuation coverage, whichever is later, to inform the Plan Administrator of the decision to continue coverage. If the Subscriber or Eligible Dependent does not choose continuation coverage, group coverage will terminate.

If the Subscriber chooses continuation coverage, the Plan Administrator is required to provide coverage identical to the coverage provided under the plan to similarly situated employees or family members. If group coverage is lost because of a termination of employment or reduction in hours, the Subscriber and Eligible Dependents may maintain continuation of coverage for 18 months. The law requires Eligible Dependents be given the opportunity to maintain continuation of coverage for 36 months in the event of the Subscriber's death, divorce, legal separation, or Medicare entitlement, or a child's loss of dependent status.

An 18-month extension of coverage is available to Eligible Dependents who elect continuation coverage if a second event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second event occurs is 36 months. A second event includes loss of dependency status. A second event occurs only if it causes an Eligible Dependent to lose coverage under the Plan as if the first event had not occurred. Eligible Dependents must notify the Plan Administrator within 60 days after the second event occurs. If group coverage is lost because of a termination of employment or reduction in hours and the Subscriber becomes entitled to Medicare benefits less than 18 months before the termination or reduction in hours, Eligible Dependents may maintain continuation coverage for up to 36 months after the date of Medicare entitlement.

A Subscriber or Eligible Dependent determined to have been disabled for Social Security purposes at the time of termination of employment or reduction in hours or who becomes disabled at any time during the first 60 days of COBRA continuation coverage and who provides notice of such determination to the Plan Administrator, may be entitled to receive up to an additional 11 months of continuation coverage, for a total maximum of 29 months. The disability must last at least until the end of the 18-month period of continuation coverage. If the individual entitled to the disability extension has nondisabled family members who are entitled to continuation coverage, those nondisabled family members also may be entitled to extend the continuation coverage to 29 months.

There is a second 60-day election period for certain individuals who lose group health coverage and are eligible for federal trade adjustment assistance. The second election period applies only to those individuals who did not elect continuation coverage under the initial 60-day election period and who meet federal trade adjustment assistance eligibility guidelines. The second 60-day election period begins on the first day of the month in which the individual is determined to be eligible for trade adjustment assistance, but in no event may elections be made later than 6 months after the loss of group coverage. If elected, continuation coverage will be measured from the date of loss of group coverage.

Notwithstanding the availability of continuation coverage, the law also provides that continuation coverage may be terminated for any of the following reasons:

1. The Group no longer provides group coverage to any of its employees;

2. Failure to make the premium payment;

3. The person receiving continuation coverage becomes covered under another benefit plan providing the same or similar coverage (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any preexisting condition of such person; (for plan years beginning on or after July 1, 1997, or later for certain plans maintained pursuant to one or more collective bargaining agreements, if the other benefit plan limits or excludes benefits for preexisting conditions but because of new rules applicable under the Health Insurance Portability and Accountability Act of 1996 those limits or exclusions would not apply to (or would be satisfied by) an individual receiving COBRA continuation coverage under this benefit plan, then this benefit plan can stop making the COBRA continuation coverage available to the individual); or

4. Entitlement to Medicare benefits.

Medical qualification is not required for a Subscriber to choose continuation of coverage. However, under the law a Subscriber may have to pay all or part of the premium for continuation coverage. The law also says that during the 180-day period ending on the expiration of the 18, 29 or 36-month continuation period, a Subscriber or Eligible Dependent who has chosen continuation coverage may be provided with the option of enrollment under a conversion health plan otherwise generally available under this Benefit Plan. An application must be submitted within 31 days to be eligible for conversion coverage. If an application is not submitted within the 31-day period, medical qualification will be required.

4.9 ERISA RIGHTS

As a Subscriber of this Benefit Plan enrolled through a group health plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Subscribers shall be entitled to:

A. Receive Information About Your Plan and Benefits.

1. Examine without charge at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Benefit Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan Administrator with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

3. Receive a summary of the annual financial report of the Benefit Plan. The Plan Administrator is required by law to furnish each Subscriber with a copy of this summary annual report.

B. Continue Group Health Plan Coverage.

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Benefit Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review your summary plan description and the document governing the Benefit Plan on the rules governing your COBRA continuation coverage rights.

C. Prudent Actions by Plan Fiduciaries.

In addition to creating rights for Subscribers, ERISA imposes duties upon the people who are responsible for the operation of the Benefit Plan. The people who operate the Benefit Plan, called "fiduciaries" of the Benefit Plan, have a duty to do so prudently and in the interest of the Members. No one, including the employer, union, or any other person, may fire or otherwise discriminate against the Subscriber in any way to prevent them from obtaining a benefit or exercising rights under ERISA.

D. Enforce Your Rights.

If a Claim for Benefits is denied or ignored, in whole or in part, the Subscriber has 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 that can be taken to enforce the above rights. For instance, if a Subscriber requests a copy of plan documents or the latest annual report from the Benefit Plan and does not receive them within 30 days, the Subscriber may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Subscriber up to $110 a day until the Subscriber receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Subscriber has a Claim for Benefits that is denied or ignored, in whole or in part, the Subscriber may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in federal court. If it should happen that Benefit Plan fiduciaries misuse the plan's money, or if the Subscriber is discriminated against for asserting their rights, the Subscriber may seek assistance from the U.S. Department of Labor, or the Subscriber may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Subscriber is successful, the court may order the person sued to pay these costs and fees. If the Subscriber loses, the court may order the Subscriber to pay these costs and fees, for example, if it finds the Subscriber's claim frivolous.

E. Assistance with Your Questions.

If the Subscriber has any questions about the Benefit Plan, the Subscriber should contact the Plan Administrator. If the Subscriber has any questions about this statement or about their rights under ERISA, or if the Subscriber needs assistance in obtaining documents from the Plan Administrator, the Subscriber should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your 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. The Subscriber may also obtain certain publications about their rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

4.10 AMENDMENT OF BENEFIT PLAN

The terms of this Benefit Plan may be amended at any time by the Plan Administrator. The Claims Administrator shall not incur any liability for benefits, expenses or other payments under this Benefit Plan as a result of any amendment of this Benefit Plan. The Plan Administrator will furnish a summary description to each Member who is receiving benefits under the Benefit Plan in accordance with ERISA §104 and applicable regulations. The Claims Administrator is not responsible for notifying Members of any amendments nor is the Claims Administrator responsible for any other duties assigned to the Plan Administrator by ERISA or the terms of this Benefit Plan.

4.11 CANCELLATION OF THIS OR PREVIOUS BENEFIT PLANS

A. If this Benefit Plan is terminated, modified or amended, coverage is automatically terminated, modified or amended for all enrolled Members of the group plan. It is the Plan Administrator's responsibility to notify Members of the termination of coverage.

B. If a Subscriber becomes ineligible for group membership under the Claims Administrator's requirement, coverage will be canceled at the end of the last month for which payment was made. In this case, payment will be made for treatment in process prior to cancellation, if such treatment is completed within 60 days and is limited to Dentures (complete and partial), Bridges, Crowns and root canal therapy. For group specific benefits, please see Section 2, Covered Services and the Benefit Plan Attachment.

C. Dental coverage while employed can only be canceled on the Group's anniversary date.

4.12 MEMBER - PROVIDER RELATIONSHIP

In addition to meeting all other requirements under this Benefit Plan benefits shall be available only upon the recommendation and while under the care and treatment of a Dentist.

Each Member is free to select a Dentist and discharge such Dentist. Dentists are free to provide medical care according to his or her own judgment. Nothing contained in this Benefit Plan will interfere with the ordinary relationship that exists between a Dentist and patient or obligate the Claims Administrator in any circumstances to supply a Dentist for any Member. The provision of medical care and/or the decision not to provide medical care may have a financial impact on the Dentist. The Member should consult with his/her Dentist regarding the nature and extent of such a financial impact, if any, as well as how it might affect medical care decisions.

A Member's dental care is between the Member and the Member's Dentist, and this Benefit Plan only explains what is or is not covered, not what dental care the Member should seek.

4.13 CLAIMS ADMINISTRATOR'S RIGHT TO RECOVERY OF PAYMENT

All Members expressly consent and agree to reimburse the Claims Administrator for benefits provided or paid for which a Member was not eligible under the terms of this Benefit Plan. Such reimbursement shall be due and payable immediately upon notification and demand by the Claims Administrator. Further, at the option of the Claims Administrator, benefits or the Allowance therefore may be diminished or reduced as an off set toward such reimbursement. Acceptance of membership fees, or providing or paying benefits by the Claims Administrator, shall not constitute a waiver of their rights to enforce these provisions in the future.

4.14 CONFIDENTIALITY

All Protected Health Information (PHI) maintained by the Claims Administrator under this Benefit Plan is confidential. Any PHI about a Member under this Benefit Plan obtained by the Claims Administrator from that Member or from a provider may not be disclosed to any person except:

A. Upon a written, dated, and signed authorization by the Member or prospective Member or by a person authorized to provide consent for a minor or an incapacitated person;

B. If PHI identifies the provider, upon a written, dated, and signed approval by the provider. However, the Claims Administrator may disclose PHI to the Health Care Data Committee for the enhancement of price competition in the health care market. The Claims Administrator may also disclose to a provider, as part of a contract or agreement in which the provider is a party, data or information that identifies a provider as part of mutually agreed upon terms and conditions of the contract or agreement;

C. If the data or information does not identify either the Member or prospective Member or the provider, the data or information may be disclosed upon request for use for statistical purposes or research;

D. Pursuant to statute or court order for the production or discovery of evidence; or

E. In the event of a claim or litigation between the Member or prospective Member and the Claims Administrator in which the PHI is pertinent.

This section may not be construed to prevent disclosure necessary for the Claims Administrator to conduct health care operations, Including utilization review or management consistent with state law, to facilitate payment of a claim, to analyze health plan claims or health care records data, to conduct disease management programs with providers, or to reconcile or verify claims under a shared risk or capitation arrangement. This section does not apply to PHI disclosed by the Claims Administrator as part of a research project approved by an institutional review board established under federal law. This section does not apply to PHI disclosed by the Claims Administrator to the insurance commissioner for access to records of the Claims Administrator for purposes of enforcement or other activities related to compliance with state or federal laws.

4.15 PRIVACY OF PROTECTED HEALTH INFORMATION

The Claims Administrator will not disclose the Member's Protected Health Information (PHI) to the Group unless the Group certifies that the Benefit Plan has been amended to incorporate the privacy restrictions required under federal and state law, and agrees to abide by them.

The Claims Administrator will disclose the Member's PHI to the Group to carry out administrative functions under the terms of the Benefit Plan, but only in accordance with applicable federal and state law. Any disclosure to and use by the Group of the Member's PHI will be subject to and consistent with this section. The Claims Administrator will not disclose the Member's PHI to the Group unless such disclosures are included in a notice of privacy practices distributed to the Member. The Claims Administrator will not disclose the Member's PHI to the Group for actions or decisions related to the Member's employment or in connection with any other benefits made available to the Member.

The following restricts the Group's use and disclosure of the Member's PHI:

A. The Group will neither use nor further disclose the Member's PHI except as permitted by the Benefit Plan or required by law.

B. The Group will ensure that anyone who receives the Member's PHI agrees to the restrictions and conditions of the Benefit Plan with respect to the Member's PHI.

C. The Group will not use or disclose the Member's PHI for actions or decisions related to the Member's employment or in connection with any other benefit made available to the Member.

D. The Group will promptly report to the Plan Administrator any use or disclosure of the Member's PHI that is inconsistent with the uses and disclosures allowed under this section upon learning of such inconsistent use or disclosure.

E. In accordance with federal law, the Group will make PHI available to the Member who is the subject of the information. Such information is subject to amendment and, upon proper notice, the Group will amend the Member's PHI where appropriate.

F. The Group will document disclosures it makes of the Member's PHI so the Plan Administrator is able to provide an accounting of disclosures as required under applicable state and federal law.

G. The Group will make its internal practices, books, and records relating to its use and disclosure of the Member's PHI available to the Plan Administrator and to the U.S. Department of Health and Human Services as necessary to determine compliance with federal law.

H. The Group will, where feasible, return or destroy all Members PHI in whatever form or medium received from the Plan Administrator, including all copies of and any data or compilations derived from and allowing identification of any Member when the Member's PHI is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member PHI, the Group will limit the use or disclosure of any Member PHI to those purposes that make the return or destruction of the information infeasible.

4.16 NOTICE OF PRIVACY PRACTICES

The Claims Administrator maintains a Notice of Privacy Practices. This Notice of Privacy Practices outlines the Claims Administrator's uses and disclosures of PHI, sets forth the Claims Administrator's legal duties with respect to PHI and describes a Member's rights with respect to PHI. Members can obtain a Notice of Privacy Practices by contacting Member Services at the telephone number and address on the back of the Identification Card.

4.17 SECURITY MEASURES FOR ELECTRONIC PROTECTED HEALTH INFORMATION

A. The Group will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Members' electronic PHI that the Group creates, receives, maintains, or transmits on the Plan Administrator's behalf.

B. The Group will report to the Plan Administrator any attempted or successful (1) unauthorized access, use, disclosure, modification, or destruction of Members' electronic PHI or (2) interference with the Group's system operations in the Group's information systems, of which the Group becomes aware, except any such security incident that results in disclosure of Members' PHI not permitted by the Benefit Plan must be reported to the Plan Administrator as required by 4.15 (D).

C. The Group will support the adequate separation between the Group and the Plan Administrator, as specified in the Benefit Plan, with reasonable and appropriate security measures.

SECTION 5
CLAIMS FOR BENEFITS AND APPEALS

The Claims Administrator shall have full discretion to interpret and determine the application of Claims for Benefits and Appeals in each and every situation. Any decisions by the Claims Administrator regarding Claims for Benefits and Appeals shall be final, conclusive and binding upon all parties.

To inquire on the Claims for Benefits and Appeals process, please contact Member Services at the telephone number and address on the back of the Identification Card.

A Member may submit a Claim for Benefits by contacting the Claims Administrator at the telephone number or address listed on the back of the Identification Card. The Member is responsible for providing the Claims Administrator with a Claim for Benefits within 18 months after the date the benefits or services offered under this Benefit Plan were incurred. A Claim for Benefits must include the information necessary for the Claims Administrator to determine benefits or services.

The Member may designate an Authorized Representative to pursue a Claim for Benefits or appeal an adverse determination from a Claim for Benefits. The designation of an Authorized Representative is limited in scope and not an assignment of benefits. It does not grant the Authorized Representative any of the Member's rights and privileges under the terms of this Benefit Plan.

Upon receipt of a Claim for Benefits under this Benefit Plan from a Member and/or the Member's Authorized Representative, the following claims review and appeals process applies:

Maximum Time Limits for Claims Processing

Type of Notice	Emergency Claim for Benefits	Pre-Service Claim for Benefits	Post-Service Claim for Benefits	Ongoing Course of Treatment Claim for Benefits
Initial Determinations (Plan) Extensions	72 Hours NONE	15 Days 15 Days	30 Days 15 Days	Notification "sufficiently in advance" of reduction or termination of benefits.*
Improperly Filed Claims (Plan)	24 Hours	5 Days	NONE	N/A
Additional Information Request (Plan)	24 Hours	15 Days	30 Days	N/A
Response to Request For Additional Information (Claimant)	48 Hours	45 Days	45 Days	N/A
Request for Appeal (Claimant)	180 Days	180 Days	180 Days	N/A
Appeal Determinations (Plan) Extensions	72 Hours NONE	30 Days NONE	60 Days NONE	As appropriate to the type of claim.

*If claim is made at least 24 hours before expiration of treatment and the claim involves an urgent care claim, the Claims Administrator's decision must be made within 24 hours of receipt of the claim.

5.1 CLAIMS FOR BENEFITS INVOLVING PREAUTHORIZATION AND PRIOR APPROVAL (PRESERVICE CLAIMS FOR BENEFITS)

A. Claims for Benefits Requiring Preauthorization or Prior Approval.

1. Claims for Benefits Requiring Preauthorization or Prior Approval. Upon receipt of a Claim for Benefits under the Benefit Plan from a Member and/or a Member's Authorized Representative that is conditioned on a Member obtaining approval in advance of obtaining the benefit or service, the Claims Administrator will notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 15 days from receiving the claim. The Claims Administrator may extend this initial time period an additional 15 days if the Claims Administrator is unable to make a determination due to circumstances beyond its control after giving the Member and/or the Member's Authorized Representative notice of the need for additional time prior to the expiration of the initial 15-day time period.

   If the Member and/or the Member's Authorized Representative improperly submits a Claim for Benefits, the Claims Administrator will notify the Member and/or the Member's Authorized Representative as soon as possible but no later than 5 days after receipt of the Claim for Benefits and provide the Member and/or the Member's Authorized Representative with the proper procedures to be followed when filing a Claim for Benefits. The Claims Administrator may also request additional or specified information after receiving a Claim for Benefits, but any such request will be made prior to the expiration of the initial 15-day time period after receiving the Claim for Benefits. Upon receiving notice of an improperly filed Claim for Benefits or a request for additional or specified information, the Member and/or the Member's Authorized Representative has 45 days in which to properly file the Claim for Benefits and submit the requested information. After receiving the properly filed Claim for Benefits or additional or specified information, the Claims Administrator shall notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 15 days after receipt of the properly filed Claim for Benefits and additional information.

2. Claims for Benefits Involving an Ongoing Course of Treatment or Number of Treatments. For services or benefits involving an ongoing course of treatment taking place over a period of time or number of treatments, the Claims Administrator will provide the Member and/or the Member's Authorized Representative with notice that the services or benefits are being reduced or terminated at a time sufficiently in advance to permit the Member and/or the Member's Authorized Representative to request extending the course of treatment or number of treatments. Upon receiving a Claim for Benefits from a Member and/or a Member's Authorized Representative to extend such treatment, the Claims Administrator will notify the Member and/or the Member's Authorized Representative of its determination as soon as possible prior to terminating or reducing the benefits or services.

3. Appeals of Claims for Benefits Requiring Preauthorization and Prior Approval. The Member and/or the Member's Authorized Representative have up to 180 days to appeal the Claims Administrator's benefit determination of a Claim for Benefits requiring Preauthorization or Prior Approval benefits or services. Upon receipt of an appeal from a Member and/or a Member's Authorized Representative, the Claims Administrator will notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 30 days after receiving the Member's and/or the Member's Authorized Representative's request for review.

B. Claims for Benefits Involving Emergency Care or Treatment

1. Claims for Benefits for Emergency Services. Upon receipt of a Claim for Benefits for Emergency Services from a Member and/or a Member's Authorized Representative, the Claims Administrator will notify the Member and/or the Member's Authorized Representative of its determination as soon as possible but no later than 72 hours after receiving the Claim for Benefits.

If the Member and/or the Member's Authorized Representative improperly submits a Claim for Benefits or the Claim for Benefits is incomplete and the Claims Administrator requests additional or specified information, the Claims Administrator will notify the Member and/or the Member's Authorized Representative as soon as possible but no later than 24 hours after receipt of the Claim for Benefits. Upon receiving notice of an improperly filed Claim for Benefits or the request from the Claims Administrator for additional or specified information, the Member and/or the Member's Authorized Representative has 48 hours to properly file the Claim for Benefits or to provide the requested information. After receiving the properly filed Claim for Benefits or requested information, the Claims Administrator shall notify the Member and/or the Member's Authorized Representative of its determination as soon as possible but no later than 48 hours after receipt of the additional or specified information requested by the Claims Administrator or within 48 hours after expiration of the Member's time period to respond.

2. Appeals of Claims for Benefits for Emergency Services. The Member and/or the Member's Authorized Representative have up to 180 days to appeal the Claims Administrator's benefit determination of a Claim for Benefits for Emergency Services. Upon receipt of an appeal from a Member and/or a Member's Authorized Representative, the Claims Administrator will notify the Member and/or the Member's Authorized Representative of its determination, whether adverse or not, as soon as possible but no later than 72 hours after receiving the Member's and/or the Member's Authorized Representative's request for review. A Member and/or a Member's Authorized Representative may request an appeal from a determination involving a Claim for Benefits for Emergency Services orally or in writing, and the Claims Administrator will accept needed materials by telephone or facsimile.

5.2 ALL OTHER CLAIMS FOR BENEFITS (POST SERVICE CLAIM FOR BENEFITS)

A. Claims for Benefits for All Other Services or Benefits. Upon receipt of a Claim for Benefits under the Benefit Plan from a Member and/or a Member's Authorized Representative, the Claims Administrator will notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 30 days from receiving the Claim for Benefits and only if the determination is adverse to the Member. The Claims Administrator may extend this initial time period in reviewing a Claim for Benefits an additional 15 days if the Claims Administrator is unable to make a determination due to circumstances beyond its control after giving the Member and/or the Member's Authorized Representative notice of the need for additional time prior to the expiration of the initial 30-day time period.

The Claims Administrator may request additional or specified information after receiving a Claim for Benefits, but any such request will be made prior to the expiration of the initial 30-day time period after receiving the Claim for Benefits. Upon receiving a request for additional or specified information, the Member and/or the Member's Authorized Representative has 45 days in which to submit the requested information. After receiving the additional or specified information, the Claims Administrator shall notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 30 days after receipt of the additional information.

B. Claims for Benefits Involving an Ongoing Course of Treatment or Number of Treatments. For a Claim for Benefits involving services or benefits involving an ongoing course of treatment taking place over a period of time or number of treatments, the Claims Administrator will provide the Member and/or the Member's Authorized Representative with notice that the services or benefits are being reduced or terminated at a time sufficiently in advance to permit the Member and/or the Member's Authorized Representative to request extending the course of treatment or number of treatments. Upon receiving a Claim for Benefits from a Member and/or a Member's Authorized Representative to extend such treatment, the Claims Administrator will notify the Member and/or the Member's Authorized Representative of its determination as soon as possible prior to terminating or reducing the benefits or services.

C. Appeals from Initial Claims for Benefits Determinations for All Other Claims for Services or Benefits. The Member and/or the Member's Authorized Representative have up to 180 days to appeal the Claims Administrator's benefit determination of a Claim for Benefits. Upon receipt of an appeal from a Member and/or a Member's Authorized Representative, the Claims Administrator will notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 60 days after receiving the Member's and/or the Member's Authorized Representative's request for review.

To inquire on the Claims for Benefits and Appeals process, please contact Member Services at the telephone number and address on the back of the Identification Card.

SECTION 6
OTHER PARTY LIABILITY

This section describes the Claims Administrator's Other Party Liability programs and coordinating benefits and services when a Member has other dental care coverage available, and outlines the Member's responsibilities under these programs. The Claims Administrator shall determine the interpretation and application of the following Other Party Liability provisions in each and every situation.

6.1 COORDINATION OF BENEFITS

This provision applies when a Member is enrolled under another limited group contract, certificate or plan (plan), whether insured or self-funded, that also provides benefits for services covered under this Benefit Plan. If the sum of benefits payable under this Benefit Plan and the other plan exceed the total allowable expense for Covered Services, the benefits payable under this Benefit Plan will be reduced so the sum of benefits payable under all plans does not exceed 100% of the total allowable expense for Covered Services.

For the purposes of this coordination of benefits provision, the following definitions apply:

"Allowable expense" means a dental care expense, including deductibles, coinsurance and copayments (if required as part of a plan), that is covered at least in part by any plan covering a Member. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense not covered by any plan covering a Member is not an allowable expense. In addition, any expense that a dental care provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an allowable expense. The following are examples of expenses that are not allowable expenses:

(1) If a Member is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(2) If a Member is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(3) If a Member is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan’s payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different from the primary plan’s payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

(4) The amount of any benefit reduction by the primary plan because a Member has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second opinions, precertifications, and preferred provider arrangements.

"Closed panel plan" means a plan that provides dental care benefits to Members primarily in the form of services through a panel of dental care providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other dental care providers, except in cases of emergency or referral by a panel member.

"Custodial parent" means the parent awarded physical custody by a court order or, in the absence of a court order, the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

A. Order of Benefits Determination Rules. The order of benefits determination rules govern the order in which this Benefit Plan and another plan will pay benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The secondary plan may reduce the benefits it pays so that the benefits payable under all plans do not total more than 100% of the total allowable expense for Covered Services.

A plan that does not contain a coordination of benefits provision that is consistent with this Benefit Plan's provision is always primary unless the rules of both plans state that this Benefit Plan is primary. An exception exists for coverage that is obtained by virtue of membership in a group that is designed to supplement part of a basic package of benefits and provides that the supplementary coverage shall be excess to any other parts of the plan provided by the policyholder.

If a Claim for Benefits or any other request for reimbursement is submitted under this Benefit Plan the order of payment will be the first of the following rules that apply:

1. Nondependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

   However, if the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

   a. Secondary to the plan covering the person as a dependent; and

   b. Primary to the plan covering the person as other than a dependent (e.g., a retired employee).

   Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

2. Dependent child covered under more than one plan. Unless there is a court order stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      (1) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

      (2) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

   b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

      (1) If a court order states that one of the parents is responsible for the dependent child's dental care expenses or dental care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no dental care coverage for the dependent child's dental care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This paragraph shall not apply with respect to any plan year during which Covered Services are paid or provided before the entity has actual knowledge of the court order provision. A copy of the court order must be provided to the Claims Administrator upon request;

      (2) If a court order states that both parents are responsible for the dependent child's dental care expenses or dental care coverage, the provisions of Section 6.1(A.)(2.)(a.) shall determine the order of benefits;

(3) If a court order states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the dependent child, the provisions of Section 6.1(A.)(2.)(a.) shall determine the order of benefits; or

(4) If there is no court order allocating responsibility for the child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:

a. The plan covering the custodial parent;

b. The plan covering the custodial parent's spouse;

c. The plan covering the non-custodial parent; and then

d. The plan covering the non-custodial parent's spouse.

c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Section 6.1(A.)(2.)(a.) or Section 6.1(A.)(2.)(b.) as if those individuals were parents of the child.

3. Active employee or retired or laid-off employee. The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired, or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

   If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. Also, this rule does not apply if the rule in Section 6.1(A.)(1.) can determine the order of benefits.

4. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, policyholder or retiree or covering the person as a dependent of an employee, member, subscriber, policyholder or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

   If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Also, this rule does not apply if the rule in Section 6.1(A.)(1.) can determine the order of benefits.

5. Longer or shorter length of coverage. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

   To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within 24 hours after coverage under the first plan ended.

   The start of a new plan does not include:

   a. A change in the amount or scope of a plan's benefits;

   b. A change in the entity that pays, provides or administers the plan's benefits; or

   c. A change from one type of plan to another, such as from a single employer plan to a multiple employer plan.

The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

6. If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

B. If it is determined this Benefit Plan is secondary, the benefits of this Benefit Plan will be reduced so that the total benefits paid or provided by all plans during a Benefit Period are not more than the total allowable expenses. In determining the amount to be paid for any claim, this Benefit Plan will calculate the benefits it would have paid in the absence of coverage under another plan and apply that calculated amount to the allowable expense under this Benefit Plan that is unpaid by the primary plan. The benefits of this Benefit Plan will then be reduced so that they and the benefits payable under the other plans for the claim do not total more than 100% of the total allowable expense for that claim. When the benefits of this Benefit Plan are reduced as described in this subsection, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Benefit Plan. In addition, if this Benefit Plan has a deductible and/or coinsurance, the deductible and/or coinsurance will be credited with any amounts that would have been credited in the absence of the other plan.

The ultimate responsibility of the Claims Administrator for payment of Covered Services will never exceed the amount payable in the absence of other coverage.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about dental care coverage and services are needed to administer this coordination of benefits provision and to determine benefits payable under this Benefit Plan and other plans. The Claims Administrator may obtain the facts it needs from or give them to other organizations or persons for the purpose of administering this provision. The Claims Administrator need not tell, or obtain the consent of, any person to do this. Each Member claiming benefits under this Benefit Plan must provide the Claims Administrator with any facts it needs to administer this provision and determine benefits payable.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

If payments have been made by the Claims Administrator for Covered Services in excess of the amount payable under this Benefit Plan, the Claims Administrator may recover the excess from any persons to or for whom such payments were made, including any Member, provider or other organization. The Member agrees to execute and deliver any documentation requested by the Claims Administrator to recover excess payments. In the sole discretion of the Claims Administrator, future payments under this Benefit Plan will be withheld until the overpayment has been recovered.

6.2 AUTOMOBILE NO-FAULT OR MEDICAL OR DENTAL PAYMENT BENEFIT COORDINATION

If a Member is eligible for basic automobile no-fault benefits or other automobile dental payment benefits as the result of accidental bodily injury arising out of the operation, maintenance or use of a motor vehicle, the benefits available under this Benefit Plan will be reduced by and coordinated with the basic automobile no-fault benefits or other automobile dental payment benefits.

6.3 DENTAL PAYMENT BENEFIT COORDINATION

If a Member is eligible for medical payment benefits provided by any other collectible insurance as a result of an injury, the benefits available under this Benefit Plan will be reduced by and coordinated with the medical payment benefits provided by any other collectible insurance not prohibited from coordination of benefits.

6.4 RIGHTS OF SUBROGATION, REIMBURSEMENT AND ASSIGNMENT

If the Claims Administrator on behalf of the Group pays benefits for Covered Services to or for a Member for any injury or condition caused or contributed to by the act or omission of any third party, the Claims Administrator on behalf of the Group shall have certain rights of assignment, subrogation and/or reimbursement as set forth below. The Claims Administrator has full discretionary authority to determine whether to exercise any or all of said rights.

A Member must notify the Claims Administrator of the circumstances of the injury or condition, cooperate with the Claims Administrator in doing whatever is necessary to enable the Claims Administrator to assert these rights, and do nothing to prejudice them. The rights stated herein apply automatically in any applicable situation. The Claims Administrator has no obligation to notify a Member of the Claims Administrator's intent to exercise one or more of these rights and the Claims Administrator's failure to provide such a notice shall not constitute a waiver of these rights.

If a Member does not comply with these provisions or otherwise prejudices the rights of the Claims Administrator on behalf of the Group to assignment, subrogation or reimbursement, the Claims Administrator shall have full discretion to withhold payment of any future benefits to or for the Member and to off set the benefits already paid to or for the Member against the payment of any future benefits to or for the Member regardless of whether or not said future benefits are related to the injury or condition. The Claims Administrator shall have full discretion to interpret these provisions and to determine their application in each and every situation. Any decisions by the Claims Administrator regarding the application of the above provisions shall be final, conclusive and binding upon all parties.

A. Right of Assignment and/or Subrogation: If a Member fails to bring a claim against a third party (including any person, firm or corporation which may be liable for or on behalf of the third party), the Claims Administrator on behalf of the Group has the right to bring said claim as the assignee and/or subrogee of the Member and to recover any benefits paid under this Benefit Plan even if the Member has not received full compensation for the injury or condition.

B. Right of Reimbursement: If a Member makes any recovery from a third party (including any person, firm or corporation which may be liable for or on behalf of the third party), whether by judgment, settlement or otherwise, the Member must notify the Claims Administrator of said recovery and must reimburse the Claims Administrator on behalf of the Group to the full extent of any benefits paid by the Claims Administrator, not to exceed the amount of the recovery. This right of reimbursement shall apply to any such recovery to the extent of any benefits paid under this Benefit Plan even if the Member has not received full compensation for the injury or condition. Any recovery the Member may obtain is conclusively presumed to be for the reimbursement of benefits paid by the Claims Administrator on behalf of the Group until the Claims Administrator has been fully reimbursed.

The Member agrees to not transfer any right to any recovery to a third party or otherwise attempt to avoid the rights of the Claims Administrator on behalf of the Group under this Benefit Plan. The Member agrees that any recovery shall be held in trust for the Claims Administrator on behalf of the Group until the Claims Administrator on behalf of the Group has been fully reimbursed and/or that the Claims Administrator on behalf of the Group shall have a lien on any recovery to the full extent of any benefits paid under this Benefit Plan. The Member agrees that to enforce its rights under this section, the Claims Administrator on behalf of the Group may pursue any and all remedies, legal or equitable, available under state or federal law, Including subrogation, breach of contract, constructive trust, equitable lien, injunction, restitution and any other remedies.

6.5 WORKERS' COMPENSATION

If benefits or compensation are available, in whole or in part, under provisions of a state workers' compensation act, laws of the United States or any state or political subdivision thereof, the benefits under this Benefit Plan will be reduced by and coordinated with such other benefits or compensation available to a Member.

If a Member is injured or suffers any condition caused or contributed to by the Member's employment, the Member must notify the Claims Administrator of the circumstances of the injury and condition, cooperate with the Claims Administrator and the United States or any state or political subdivision thereof in doing whatever is necessary to determine the availability of such benefits or compensation, and do nothing to prejudice them.

In the event of the failure of a Member to comply with this provision or if a Member prejudices that Member's right or entitlement to benefits or compensation available under such a program, the Claims Administrator shall have full discretion to withhold payment of any future benefits to or for the Member and to off set the benefits already paid to or for the Member against the payment of any future benefits to or for the Member regardless of whether or not said future benefits are related to the injury or condition.

SECTION 7
DEFINITIONS

This section defines the terms used in this Benefit Plan. These terms will be capitalized throughout this Benefit Plan when referred to in the context defined. The Claims Administrator shall have full discretion to interpret and determine the application of the Definitions in each and every situation. Any decisions by the Claims Administrator regarding the Definitions shall be final, conclusive and binding upon all parties.

7.1 **ABUTMENT** - a tooth or implant used to support a prosthesis.

7.2 **ACTIVE APPLIANCE** - an orthodontic treatment device (such as a brace) that actually moves teeth.

7.3 **ALLOWANCE OR ALLOWED CHARGE** - the maximum dollar amount that payment for a procedure or service is based on as determined by the Claims Administrator.

7.4 **ANESTHESIA** - a medication used for the loss of pain sensation.

A. local anesthesia (one injection per quadrant per visit).

B. analgesia (nitrous oxide).

C. general anesthesia (intravenous sedation) when provided in connection with covered Oral Surgery services by an Anesthesiologist, Nurse Anesthetist or Oral Surgeon.

7.5 **ANNUAL ENROLLMENT PERIOD** - a period of time an eligible employee or Eligible Dependent may apply for coverage under this Benefit Plan. The Annual Enrollment Period will be a period of 31 days prior to the Group's anniversary date.

7.6 **AUTHORIZED REPRESENTATIVE** - a health care provider or other individual authorized by the Member to inquire or request information on a Member.

7.7 **BENEFIT MAXIMUM** - the total dollar amount of Covered Services that will be allowed for each Member during a Benefit Period or lifetime.

7.8 **BENEFIT PERIOD** - a specified period of time when benefits are available for Covered Services under this Benefit Plan. A Claim for Benefits will be considered for payment only if the date of service or supply was within the Benefit Period. All benefits are determined on a calendar year (January 1 through December 31) Benefit Period.

7.9 **BENEFIT PLAN** - the agreement with the Claims Administrator, Including the Subscriber's application, Identification Card, the Service Agreement, this Summary Plan Description, the Benefit Plan Attachment and any supplements, endorsements, attachments, addenda or amendments.

7.10 **BENEFIT PLAN ATTACHMENT** - the statement accompanying the Identification Card that identifies current Benefit Plan information.

7.11 **BENEFIT PLAN NUMBER** - the number assigned by the Claims Administrator and listed on the Identification Card identifying the Subscriber for administrative purposes.

7.12 **BITEWING** - dental X-rays showing the area around the teeth.

7.13 **BRIDGE** - a prosthetic replacement of one or more missing teeth:

A. a fixed partial Denture is cemented or attached to the Abutment teeth or implant Abutments adjacent to the space.

B. a removable partial Denture (removable Bridge) is cemented or attached to a framework that can be removed by the patient.

7.14 **BRUXISM** - the grinding of the teeth.

7.15 **CARIES** - a commonly used term for tooth decay.

7.16 **CAVITY** - the decay in a tooth caused by Caries.

7.17 **CLAIM FOR BENEFITS** - a request for a benefit or benefits under the terms of this Benefit Plan made by a Member in accordance with the Claims Administrator's reasonable procedures for filing a Claim for Benefits as outlined in Section 5, Claims for Benefits and Appeals. A Claim for Benefits involving payment of a claim shall be made promptly and in accordance with state law.

7.18 **CLAIMS ADMINISTRATOR** - Blue Cross Blue Shield of North Dakota, a legal trade name of Noridian Mutual Insurance Company. Also referred to as BCBSND.

7.19 **CLASS OF PARTICIPATION** - the type of coverage the Subscriber is enrolled under, identifying who is eligible to receive benefits for Covered Services under this Benefit Plan. Classes of Participation are as follows:

A. **Single Participation** - Subscriber only.

B. **Family Participation** - Subscriber and Eligible Dependents.

7.20 **COST SHARING AMOUNTS** - the dollar amount a Member is responsible for paying when Covered Services are received from a Dentist. Cost Sharing Amounts include Coinsurance, Copayment and Deductible Amounts. Applicable Cost Sharing Amounts are identified in Section 1, Schedule of Benefits and Section 2, Covered Services. Participating Dentists may bill you directly or request payment of Coinsurance, Copayment and Deductible Amounts at the time services are provided.

A. **Coinsurance Amount** - a percentage of the Allowed Charge for Covered Services that is a Member's responsibility.

B. **Copayment Amount**- a specified dollar amount payable by the Member for certain Covered Services. Health care providers may request payment of the Copayment Amount at the time of the service.

C. **Deductible Amount** - a specified dollar amount payable by the Member for certain Covered Services received during the Benefit Period. The Deductible Amount renews on January 1 of each consecutive Benefit Period.

Any Deductible Amount(s) met during the last 3 months of a Benefit Period is carried forward and applied toward the Deductible Amount for the following Benefit Period.

7.21 **COVERED SERVICE** - services and supplies that are appropriate and necessary for the treatment of a dental disease or accident for which benefits are available when provided by a Dentist.

7.22 **CROWN** - the restoration covering or replacing the major part of a tooth.

7.23 **DECIDUOUS** - the primary teeth.

7.24 **DENTAL PLAN** - identifies the benefits and outlines the level of reimbursement for benefits available under the Subscriber's Benefit Plan.

7.25 **DENTIST** - a Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) who is licensed to practice dentistry at the time and place Covered Services are performed.

A. **Participating Dentist** - any Dentist who has entered into a participation agreement with the Claims Administrator to provide Covered Services to a Member for an agreed upon payment.

B. **Nonparticipating Dentist** - a Dentist who does not have a participation agreement with the Claims Administrator.

7.26 **DENTURE** - an artificial substitute for natural teeth and adjacent tissues.

A. **Immediate Denture** - the prosthesis constructed for placement immediately after the removal of remaining natural teeth.

B. **Rebase of Denture** - the process of refitting a Denture by replacing the base material.

C. **Reline of Denture** - the process of resurfacing the tissue side of a Denture with new base material.

7.27 **ELIGIBLE DEPENDENT** - a dependent of the Subscriber who qualifies for membership under this Benefit Plan in accordance with the requirements specified below:

A. The Subscriber's spouse under a legally existing marriage as determined by the jurisdiction in which the marriage occurred.

B. The Subscriber’s domestic partner of the same or opposite gender. To be eligible for benefits, the domestic partner must meet all of the following criteria:

1. be at least 18 years of age;
2. not be legally married to anyone nor involved in another domestic partnership;
3. is not related to the Subscriber by blood; and
4. has been residing with the Subscriber continuously for at least the past 12 consecutive months.

The Subscriber and the domestic partner must demonstrate financial interdependence and be jointly responsible for each other’s basic living expenses.

An affidavit attesting to the domestic partnership must be completed and returned to Human Resources.

The domestic partner and the domestic partner's children are not eligible for coverage if the domestic partner has other group coverage available to them.

C. The Subscriber's or the Subscriber's living, covered spouse's or domestic partner's children under the age of 26 years. Children are considered under age 26 until the end of the month in which the child becomes 26 years of age. The term child or children includes:

1. Children physically placed with the Subscriber for adoption or whom the Subscriber or the Subscriber's living, covered spouse or domestic partner has legally adopted.

2. Children living with the Subscriber for whom the Subscriber or the Subscriber's living, covered spouse or domestic partner has been appointed legal guardian by court order.

3. The Subscriber's grandchildren or those of the Subscriber's living, covered spouse or domestic partner if: (a) the parent of the grandchild is unmarried, (b) the parent of the grandchild is covered under this Benefit Plan and (c) both the parent and the grandchild are primarily dependent on the Subscriber for support. If a lapse in coverage occurs due to ineligibility of the parent under this Benefit Plan, the grandchild cannot be reenrolled unless the Subscriber has been appointed legal guardian.

4. Children for whom the Subscriber or the Subscriber's living, covered spouse or domestic partner are required by court order to provide dental benefits.

5. Children beyond the age of 26 who are incapable of self support because of intellectual disability or physical handicap that began before the child attained age 26 and who are primarily dependent on the Subscriber or the Subscriber's spouse or domestic partner for support. Coverage for such a disabled child will continue for as long as the child remains unmarried, disabled and the Subscriber's dependent for federal income tax purposes. The Subscriber may be asked periodically to provide evidence satisfactory to the Claims Administrator of these disabilities.

7.28 **ENDODONTICS** - the treatment of disease and injuries of the inner tooth (pulp) and surrounding area.

7.29 **EXPERIMENTAL OR INVESTIGATIVE** - the use of any treatment, procedure, facility, equipment, drug, device or supply not accepted as standard dental treatment, as determined by the Claims Administrator in its sole discretion, of a dental disease, condition or injury or any of such items requiring federal or other government agency approval not granted at the time services were provided.

7.30 **EXPLANATION OF BENEFITS** - a document sent to the Member by the Claims Administrator after a claim for reimbursement has been processed. It includes the patient's name, claim number, type of service, Dentist, date of service, charges submitted for the services, amounts covered by this Benefit Plan, noncovered services, Cost Sharing Amounts and the amount of the charges that is the Subscriber's responsibility. This form should be carefully reviewed and kept with other important records.

7.31 **FILLING** - a term used for the restoration of lost tooth structure by using materials such as metal, alloy, plastic or cement.

A. **Amalgam** - the alloy used in direct dental restorations.

B. **Composite** - a dental restorative material made up of disparate or separate parts.

7.32 **FLUORIDE** - a solution that is topically applied to the teeth for the purpose of preventing dental decay.

7.33 **GINGIVAL CURETTAGE** - a scraping or cleaning of the walls of a cavity or gingival pocket.

7.34 **GRID DENTAL PROGRAM** - The Dental GRID Corporation, with which the Claims Administrator has a network arrangement, has a national dental network. This allows Members seeking Covered Services outside the geographic area the Claims Administrator serves with access to negotiated pricing for Dentists participating in the GRID Dental Program.

7.35 **GROUP** - the Plan Sponsor that has signed an agreement with the Claims Administrator to provide benefits for its eligible employees and Eligible Dependents.

7.36 **IDENTIFICATION CARD** - a card issued in the Subscriber's name identifying the Benefit Plan Number of the Member.

7.37 **IMPACTED TOOTH** - an unerupted or partially erupted tooth that is positioned against another tooth, bone or soft tissue so that complete eruption is unlikely.

7.38 **INCLUDING** - means including, but not limited to.

7.39 **LIFETIME MAXIMUM** - the total dollar amount of Covered Services an eligible Member may receive during a lifetime while enrolled under a Benefit Plan sponsored by the Group. The benefit amounts paid under all previous Benefit Plans sponsored by the Group will be applied toward the Lifetime Maximum of this Benefit Plan.

7.40 **MALOCCLUSION** - the improper alignment of biting and chewing surfaces of upper and lower teeth.

7.41 **MAXIMUM BENEFIT ALLOWANCE** - the maximum amount of benefits, expressed in dollars or visits, available under a Benefit Plan sponsored by the Group for a specified Covered Service.

7.42 **MEDICAMENTS** - Includes oral antibiotics, oral sedatives and topical fluorides dispensed in the Dentist's office for home use. Prescription medications or drugs are not considered Medicaments.

7.43 **MEMBER** - the Subscriber and, if another Class of Participation is in force, the Subscriber's Eligible Dependents.

7.44 **ORAL AND MAXILLOFACIAL SURGERY** - the dental surgical services that are limited to the diagnosis, surgical and adjunctive treatment of diseases, injuries, deformities, defects and aesthetic aspects of the oral and maxillofacial area.

7.45 **ORTHODONTIC** - the interception and treatment of Malocclusion of the teeth and their surrounding structures.

7.46 **PERIODONTIC** - the practice limited to the treatment of diseases of the supporting or surrounding tissues of the teeth.

7.47 **PERMANENT TEETH** - the natural teeth that replace the deciduous or primary teeth.

7.48 **PLAN ADMINISTRATOR** - the administrator of the Plan as defined by Section 3(16) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

7.49 **PONTIC** - the term used for the artificial tooth on a fixed partial Denture (Bridge).

7.50 **PROPHYLAXIS** - the scaling and polishing procedure performed to remove coronal plaque, calculus and stains.

7.51 **PROSTHESIS** - any device or appliance replacing one or more missing teeth and, if required, associated structures, Including Abutment Crowns and Abutment inlays or onlays, Bridges or Dentures.

7.52 **PROTECTED HEALTH INFORMATION (PHI)** - individually identifiable health information, including summary and statistical information, collected from or on behalf of a Member that is transmitted by or maintained in electronic media, or transmitted or maintained in any other form or medium and that:

A. is created by or received from a health care provider, health care employer, or health care clearinghouse;
B. relates to a Member's past, present or future physical or mental health or condition;
C. relates to the provision of health care to a Member;
D. relates to the past, present, or future payment for health care to or on behalf of a Member; or
E. identifies a Member or could reasonably be used to identify a Member.

Educational records and employment records are not considered PHI under federal law.

7.53 **SUBSCRIBER** - an employee whose application for membership has been accepted, whose coverage is in force with the Claims Administrator and in whose name the Identification Card and Benefit Plan Attachment are issued. A Subscriber is an eligible employee or other individual who meets and continues to meet all applicable eligibility requirements and who is enrolled and actually covered under this Benefit Plan.

7.54 **TREATMENT PLAN** - a written report prepared by the Dentist that recommends the treatment of a dental disease, defect or injury for a Member.

7.55 **WAITING PERIOD** - a period of 270 days the Member is not entitled to benefits for specified services, beginning on the individual Member's effective date under this Benefit Plan. Continuous coverage under employer group dental coverage will apply toward the Waiting Period. Members under age 19 will not be subject to a Waiting Period.