BlueDental℠ Elite+ 50 1500
Schedule of Benefits

City of Minot - Retiree
250742
Effective Date: January 1, 2024

The Schedule of Benefits describes the services for which benefits are available under this Benefit Plan subject to the definitions, exclusions, conditions and limitations of this Benefit Plan.

Please retain this Schedule of Benefits to determine Covered Services for this Benefit Plan.

The Claims Administrator shall determine the interpretation and application of the Covered Services in each and every situation.

Service Category	Plan Pays	Deductible Application
Diagnostic Services		
Oral Evaluations (Exams)*	**100%**	**No**
Radiographs		
Bitewings*	**100%**	**No**
Full mouth*	**100%**	**No**
Occlusal Films*	**100%**	**No**
Preventive Services		
Prophylaxis (Cleanings)*	**100%**	**No**
Fluoride Varnish*	**100%**	**No**
Topical Fluoride*	**100%**	**No**
Sealants	**80%**	**Yes**
Space Maintainers	**80%**	**Yes**
Restorative Services		
Amalgam Restorations	**80%**	**Yes**
Resin Based Composite-Anterior (White Fillings)	**80%**	**Yes**
Resin Based Composite-Posterior (White Fillings)	**80%**	**Yes**
Single Crowns	**50%**	**Yes**
Single Implant Crowns	**50%**	**Yes**
Stainless Steel Crowns	**50%**	**Yes**
Inlays	**50%**	**Yes**
Onlays	**50%**	**Yes**
Inlay Repairs	**50%**	**Yes**
Onlay Repairs	**50%**	**Yes**
Crown Repair	**50%**	**Yes**
Endodontic Services		
Endodontic Therapy (Root canals, etc.)	**80%**	**Yes**
Root Canal Retreatment	**80%**	**Yes**
Apicoectomy/Periradicular (Root Surgery)	**80%**	**Yes**

Service Category	Plan Pays	Deductible Application
Periodontal Services		
Surgical Periodontics	**80%**	**Yes**
Non-Surgical Periodontics	**80%**	**Yes**
Periodontal Maintenance	**80%**	**Yes**
Prosthodontic Services		
Removable Complete and Partial Dentures	**50%**	**Yes**
Fixed Partial Dentures (Bridges)	**50%**	**Yes**
Adjustments and Repairs of Complete and Partial Dentures	**50%**	**Yes**
Implant Services		
Surgical Placement	**50%**	**Yes**
Supporting Structures	**50%**	**Yes**
Treatment of Implant Defects	**50%**	**Yes**
Bone Grafts	**50%**	**Yes**
Fixed Partial Denture	**50%**	**Yes**
Removable Denture	**50%**	**Yes**
Cone Beam CT Images*	**100%**	**No**
Removal of Teeth		
Simple Extractions	**80%**	**Yes**
Surgical Extractions	**80%**	**Yes**
Complex Oral Surgery	**50%**	**Yes**
Adjunctive General Services		
Consultations	**80%**	**Yes**
General Anesthesia, Nitrous Oxide and/or IV Sedation	**80%**	**Yes**
Palliative Treatment (Emergency)*	**100%**	**No**
Orthodontic Services		
Orthodontics Services	**50%**	**No**

Deductibles

Individual Participation	$50 per Benefit Period
Parent and Child Participation	$100 per Benefit Period
Parent and Children Participation	$100 per Benefit Period
Two Person Participation	$100 per Benefit Period
Family Participation	$100 per Benefit Period

Benefit Maximums

$1,500 per Member per Benefit Period.

$2,000 Lifetime Maximum per Member for Orthodontic Services.

**Covered Service does not apply to benefit maximums.*

LIMITATIONS

Covered Services are limited as detailed below. Services are covered until 12:01 a.m. of the birthday when the patient reaches any stated age:

1. Full mouth x-rays or panoramic x-rays – one per five years.

2. Bitewing x-rays – one set per calendar year.

3. Oral Evaluations: – two per calendar year, one additional for Members under the care of a medical professional during pregnancy.

    - Comprehensive and periodic – two of these services per calendar year. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three or more years.
    - Limited problem focused and consultations – one per calendar year.
    - Detailed problem focused – one per Dentist per patient per calendar year per eligible diagnosis.

4. Prophylaxis – four per calendar year, one additional for Members under the care of a medical professional during pregnancy.

5. Fluoride treatment – two per calendar year.

6. Space maintainers – one per five years for Members through age 13.

7. Sealants – one per tooth per three year period for Members through age 18.

8. Prefabricated stainless steel crowns – one per tooth per lifetime.

9. Periodontal Services:

    - Full mouth debridement – one per Member per lifetime.
    - Periodontal maintenance following active periodontal therapy – four per calendar year in combination with routine prophylaxis.
    - Periodontal scaling and root planing – one per 36 months per area of the mouth.
    - Surgical periodontal procedures – one per 36 months per area of the mouth.
    - Guided tissue regeneration – one per tooth per lifetime.

10. Replacement of restorative services only when they are not, and cannot, be made serviceable:

    - Basic restorations – not within 24 months of previous placement of any basic restoration.
    - Single crowns, inlays, onlays – not within five years of previous placement of any of the procedures in this category.
    - Buildups and posts and cores – not within five years of previous placement of any of the procedures in this category.
    - Replacement of natural tooth/teeth in an arch – not within five years of a fixed partial denture, full denture or partial removable denture.

11. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within six months of insertion by the same Dentist. Subsequent denture relining or rebasing limited to once every 36 months thereafter.

12. Implant Services – Surgical implant procedures, including prosthetic restoration.

    - Cone beam CT images – one per five years.

13. Pulpal therapy – one per primary tooth per lifetime only when there is no permanent tooth to replace it. Eligible teeth limited to primary anterior teeth under age six and primary posterior molars under age 12.

14. Root canal retreatment – one per tooth per lifetime.

15. Recementation – one per 12 months. Recementation during the first 12 months following insertion for any preventive, restorative or prosthodontic service by the same Dentist is included in the preventive, restorative or prosthodontic service benefit.

16. Payment for orthodontic services, if covered, shall cease at the end of the month after termination by the Claims Administrator.

17. Intraoral films:

    - Periapical – four per calendar year per Dentist if not performed in conjunction with definitive procedures.
    - Occlusal – two per two calendar years under age eight.

18. Occlusal guard for treatment of bruxism allowed once every 3 years.

19. General anesthesia and IV sedation: a total of 60 minutes per session.

Group Dental Care Plan

Summary Plan Description

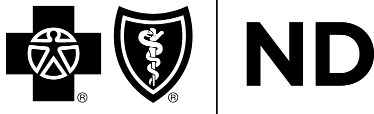
BlueDental℠ Elite+ 50 1500

City of Minot - Retiree
250742
January 1, 2024

This dental plan is that of your employer. Blue Cross Blue Shield of North Dakota is serving only as the Claims Administrator and does not assume any financial risk.

01/01/2024 29381308

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



In accordance with federal regulations, Blue Cross Blue Shield of North Dakota is required to provide you the following disclosure:

Blue Cross Blue Shield of North Dakota complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex. Blue Cross Blue Shield of North Dakota does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, sexual orientation or sex.

Blue Cross Blue Shield of North Dakota:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call Member Services at 1-844-363-8457 (toll-free) or through the North Dakota Relay at 1-800-366-6888 or 711.

If you believe that Blue Cross Blue Shield of North Dakota has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex, you can file a grievance with:

Civil Rights Coordinator
4510 13th Ave S
Fargo, ND 58121
701-297-1638 or North Dakota Relay at 800-366-6888 or 711
701-282-1804 (fax)
CivilRightsCoordinator@bcbsnd.com (email) (Communication by unencrypted email presents a risk.)

You can file a grievance in person or by mail, fax, or email within 180 days of the date of the alleged discrimination. Grievance forms are available at http://www.bcbsnd.com/report or by calling 1-844-363-8457. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
800-368-1019 or 800-537-7697 (TDD)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-363-8457 (TTY: 1-800-366-6888 o 711).

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-363-8457 (TTY: 1-800-366-6888 oder 711).

中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-363-8457（TTY：1-800-366-6888 或 711）。

Oroomiffa (Oromo)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-363-8457 (TTY: 1-800-366-6888 ykn 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-844-363-8457 (TTY: 1-800-366-6888 hoặc 711).

Ikirundi (Bantu – Kirundi)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu.
Woterefona 1-844-363-8457 (TTY: 1-800-366-6888 canke 711).

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-363-8457 (رقم هاتف الصم والبكم: 1-800-366-6888 أو711).

Kiswahili (Swahili)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo.
Piga simu 1-844-363-8457 (TTY: 1-800-366-6888 au 711).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-844-363-8457 (телетайп: 1-800-366-6888 или 711).

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-363-8457
（TTY: 1-800-366-6888 または 711）まで、お電話にてご連絡ください。

नेपाली (Nepali)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस्
1-844-363-8457 (टिटिवाइ: 1-800-366-6888 वा 711) ।

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Appelez le 1-844-363-8457 (ATS : 1-800-366-6888 ou 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-363-8457
(TTY: 1-800-366-6888 또는 711)번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-363-8457 (TTY: 1-800-366-6888 o 711).

Norsk (Norwegian)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-844-363-8457 (TTY: 1-800-366-6888 eller 711).

Diné Bizaad (Navajo)

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hólǫ́, kojį' hódíílnih 1-844-363-8457 (TTY: 1-800-366-6888 éí doodagó 711.)

MEMBER SERVICES

Questions?	Our Member Services staff is available to answer questions about your coverage.
Call Member Services:	Monday through Friday 7:30 a.m. - 5:00 p.m. CST 1-844-653-4056
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 Blue Cross Blue Shield of North Dakota 4510 13th Avenue South Fargo, North Dakota 58121
Mailing Address:	Claim reviews, requests and inquiries should be sent to: Dental Claims Administrator P.O. Box 69446 Harrisburg, Pennsylvania 17106-9446
Internet Address:	www.BCBSND.com

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 Administrative 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 Administrative Service Agreement, the provisions of the Administrative 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 Administrative 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

City of Minot Group Benefit Plan

NAME AND ADDRESS OF EMPLOYER (PLAN SPONSOR)

City of Minot
PO Box 5006
Minot, North Dakota 58702

PLAN SPONSOR'S IRS EMPLOYER IDENTIFICATION NUMBER

45-6002126

PLAN NUMBER ASSIGNED BY THE PLAN SPONSOR

501

TYPE OF WELFARE PLAN

Dental

TYPE OF ADMINISTRATION

This is a self-funded employee welfare benefit plan. This plan is funded by City of Minot. 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, ND 58121

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

City of Minot
PO Box 5006
Minot, North Dakota 58702
701-857-4773

NAME AND ADDRESS OF AGENT FOR SERVICE OF LEGAL PROCESS

Plan Administrator:

Human Resource Director
City of Minot
PO Box 5006
515 2nd Avenue Southwest
Minot, North Dakota 58702

Claims Administrator:

Don Campbell
Blue Cross Blue Shield of North Dakota
4510 13th Avenue South
Fargo, ND 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

Senior Human Resource Generalist
Human Resource Director
Financial Specialist
HR Generalist
Accountant
Comptroller
Finance Director

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

The City of Minot also offers a dental benefit for its retirees effective January 1, 2020.

The type of dental and/or vision plan the retiree has during retirement depends on the type of plan the retiree has at the time they leave employment (example: individual plan, family plan). If an employee leaves employment with an individual plan, they can continue with an individual plan until they choose to cancel the plan. If an employee leaves employment with a family plan, the retiree and spouse can continue with a family plan until they choose to cancel the plan. A retiree can only choose to continue dental and/or vision into retirement, if they were actively enrolled in the applicable plan prior to the onset of retirement.

If a retiree or retiree's spouse discontinues dental and/or vision coverage at any time during retirement, they are not allowed back on the City's dental and/or vision plan.

The retiree is allowed to change from a family to an individual plan by removing a spouse from the policy. However, the retiree is not allowed to add a spouse or change from an individual plan to a family plan at any time after leaving employment.

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 the Covered Services section page numbers.

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

Dental premium amounts are the retiree’s responsibility.

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

December 31

DENTAL BENEFITS
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INTRODUCTION

This Benefit Plan provides information about the Member's dental coverage. Read it carefully and keep it in a safe place. Review it to become familiar with your benefits.

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 Certificate Holder will receive an Identification Card. All Members share this Unique Member Identifier. Carry the Identification Card at all times. If the Identification Card is lost, contact the Claims Administrator to request a replacement. The Certificate Holder 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.

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 the services you received within 12 months after the date the services were provided. The written notice must include information necessary for the Claims Administrator to determine benefits.

The Certificate Holder 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 the Claims Administrator is not contracting as an agent of the Association. The Certificate Holder 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 Certificate Holder for any of Blue Cross Blue Shield of North Dakota's obligations to the Certificate Holder 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.

The Claims Administrator shall determine the interpretation and application of the provisions of the Benefit Plan in each and every situation.

SECTION 1
HOW THE BENEFIT PLAN WORKS{ TC "Section 1 HOW THE BENEFIT PLAN WORKS" \l 1 }

1.1 CHOICE OF PROVIDER

The Member may choose any licensed Dentist for services. However, Out-of-Pocket Expenses will vary depending upon whether or not the Dentist is in the Claims Administrator's network. If the Member chooses a Participating Dentist, it may limit Out-of-Pocket Expenses. Participating Dentists agree by contract to accept Maximum Allowable Charges as payments in full for Covered Services. Participating Dentists also complete and send claims directly to the dental claims administrator for processing. To find a Participating Dentist, visit the Claims Administrator's website at www.BCBSND.com or call the telephone number listed in the Benefit Plan or on the Identification Card.

If the Member uses a Nonparticipating Dentist, the Member may have to pay the Dentist at the time of service, complete and submit their own claims and wait for the Company to reimburse them. The Member will be responsible for the Dentist's full charge which may exceed the Maximum Allowable Charge and result in higher Out-of-Pocket Expenses.

1.2 CLAIM FORMS

The Claims Administrator, upon receipt of a notice of claim, will furnish claim forms for filing claims. If forms are not furnished within 15 days after receipt of notice, the Member shall be deemed to have complied with the required time for filing a claim upon submitting written proof of the occurrence and a written statement of the nature and extent for which the claim is being made.

1.3 PROOF OF LOSS

Written proof of loss must be furnished to the Claims Administrator in the case of claim for loss for which this Benefit Plan provides any periodic payment contingent upon continuing loss within 30 days after the termination of the period for which the Claims Administrator is liable and in the case of a claim for any other loss within 90 days after the date of such loss. Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not possible to give proof within the time provided and such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

SECTION 2
COVERED SERVICES{ TC "**Section 2** COVERED SERVICES"\l 1 }

2.1 COVERED SERVICES

Benefits and any applicable Coinsurance, Deductibles, Annual Maximums and Lifetime Maximums are shown on the attached Schedule of Benefits. Covered Services must be Dentally Necessary and are subject to frequency or age Limitations as detailed on the Schedule of Benefits.

2.2 PREDETERMINATION

A predetermination is a request for the Claims Administrator to estimate benefits for a dental treatment the Member has not received. Predetermination is not required for any benefits under the Plan. In estimating benefits, the Claims Administrator looks at patient eligibility, dental necessity and the Plan's coverage for the treatment. Payment of benefits for a predetermined service is subject to the Member's continued eligibility in the Plan. At the time the claim is paid, the Claims Administrator may also correct mathematical errors, coordinate benefits and make adjustments to comply with the Member's current Plan and applicable Annual Maximums, Lifetime Maximums or on the date of service.

2.3 PAYMENT OF BENEFITS

If you have treatment performed by a Participating Dentist, the Claims Administrator will pay covered benefits directly to the Participating Dentist. Both the Member and the Dentist will be notified of benefits covered, the Claims Administrator's payment and any Out-of-Pocket Expenses. Payment will be based on the Maximum Allowable Charge the Member's Participating Dentist has contracted to accept. Maximum Allowable Charges may vary depending on the geographical area of the dental office and the contract between the Claims Administrator and the participating Dentist rendering the service. Benefits for covered dental emergency services provided by a Nonparticipating Dentist will be paid at the same level that would have been paid had the services been rendered by a Participating Dentist.

If the Member receives treatment from a Nonparticipating Dentist, the Claims Administrator will send payment for Covered Services to the Member unless the claim indicates that payment should be sent directly to the Member's treating Dentist. This is called assignment of benefits and is available for care delivered by Nonparticipating Dentists. The Member will be notified of the services covered, the Claims Administrator's payment and any Out-of-Pocket Expenses. The Member will be responsible to pay the Dentist any difference between the Claims Administrator's payment and the Dentist's full charge for the services. Nonparticipating Dentists are not obligated to limit their fees to the Claims Administrator's Maximum Allowable Charges.

For an unmarried child who has coverage through a non-custodial parent, the Claims Administrator will provide information to the custodial parent necessary for the child to obtain benefits through that coverage. The Claims Administrator will permit the custodial parent, the provider of health care, with the custodial parent's approval, or the department of human services, as the custodial parent's assignee, to submit claims for covered services without the approval of the non-custodial parent. The Claims Administrator will make payments on claims submitted, directly to the custodial parent, provider or department of human services.

The Claims Administrator is not liable to pay benefits for any services started prior to a Member's Effective Date of coverage. Multi-visit procedures are considered started when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. Procedures started prior to the Member's Effective Date are the liability of the Member.

The Claims Administrator does not disclose claim or eligibility records except as allowed or required by law and then in accordance with federal and state law. The Claims Administrator maintains physical, electronic, and procedural safeguards to guard claims and eligibility information from unauthorized access, use and disclosure.

2.4 OVERPAYMENT

If the Claims Administrator makes an overpayment for benefits, the Claims Administrator has the right to recover the overpayment either from the Member or from the person or Dentist to whom it was paid. The Claims Administrator will recover the overpayment either by requesting a refund or offsetting the amount overpaid from future claim payments. This recovery will follow any applicable state laws or regulations. The Member must provide any assistance necessary, including furnishing information and signing necessary documents, for the Claims Administrator to be reimbursed.

SECTION 3
EXCLUSIONS{ TC "Section 3 EXCLUSIONS"\l 1 }

This Plan does not meet the minimum essential health benefit requirements for pediatric oral health as required under the Federal Affordable Care Act.

Only American Dental Association procedure codes are covered.

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

The following service, supplies or charges are excluded:

1. Started prior to the Member's Effective Date or after the Termination Date of coverage under the Administrative Service Agreement (Including, multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays and dentures).

2. For house or hospital calls for dental services and for hospitalization costs (facility-use fees).

3. That are the responsibility of Workers' Compensation or employer's liability insurance, the Member's medical plan or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. To the extent the Claims Administrator's benefits are paid in excess of third-party benefits, the Claims Administrator has the right of recovery from the Member or provider who received overpayment.

4. For prescription and non-prescription drugs, vitamins or dietary supplements.

5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.

6. Which are Cosmetic in nature as determined by the Claims Administrator (Including, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

7. For congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone or required as the result of orthognathic surgery including orthodontic treatment).

8. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Benefit Plan. Examples of these jaw joint problems are temporomandibular joint disorders (TMJ) and craniomandibular (CMJ) disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

9. For treatment of malignancies or neoplasms.

10. Services and/or appliances that alter the vertical dimension (Including, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

11. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.

12. Maxillofacial prosthetics.

13. Preventive restorations.

14. Periodontal splinting of teeth by any method.

15. For duplicate dentures, prosthetic devices or any other duplicative device.

16. For which in the absence of insurance the Member would incur no charge.

17. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.

18. For any condition caused by or resulting from declared or undeclared war or act thereof or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

19. For claims submitted to the Claims Administrator in excess of 12 months after the date of service.

20. Incomplete treatment (Including patient does not return to complete treatment) and temporary services (Including temporary restorations).

21. Procedures that are:

    - part of a service but are reported as separate services; or
    - reported in a treatment sequence that is not appropriate; or
    - misreported or that represent a procedure other than the one reported.

22. Specialized procedures and techniques (Including precision attachments, copings and intentional root canal treatment).

23. Fees for broken appointments.

24. Those specifically listed on the Schedule of Benefits as "Not Covered" or "Plan Pays 0%".

25. Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the Claims Administrator shall determine the interpretation and application.

SECTION 4
GENERAL PROVISIONS{ TC "Section 4 GENERAL PROVISIONS" \l 1 }

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 Certificate Holder 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.

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 or later than 3 years after the expiration of the time within which notice of a claim is required by this Benefit Plan.

4.4 NOTIFICATION REQUIREMENTS AND SPECIAL ENROLLMENT PROVISIONS

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

B. The Certificate Holder 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 Certificate Holder marries, Eligible Dependents may be added as Members to the Certificate Holder's existing Benefit Plan, if an application is submitted within 31 days of the date of marriage. The effective date of coverage for the Eligible Dependent will be the first day of the month following enrollment.

   If the Certificate Holder marries and the application is not submitted within the 31-day period, the Eligible Dependent may apply for coverage during the Annual Enrollment Period.

2. If, because of legal separation, divorce, annulment or death, the Certificate Holder's spouse is no longer eligible for coverage under this Benefit Plan, the Certificate Holder's spouse may be eligible for continued dental coverage. See Section 4.7.

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

C. The Certificate Holder is responsible for notifying the Group or Plan Administrator, if other than the Group 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 date of birth, physical placement or court order. The following provisions will apply:

   1. The Certificate Holder 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.

   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.

   3. Children for whom the Certificate Holder or the Certificate Holder's living, covered spouse 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.

   4. Children for whom the Certificate Holder or the Certificate Holder's living, covered spouse 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.

   5. If any of the Certificate Holder's children beyond the age of 26 are medically certified as intellectually disabled or physically disabled, the Certificate Holder may continue their coverage under Parent and Child, Parent and Children or Family Participation. Coverage will remain in effect as long as the child remains disabled, unmarried and financially dependent on the Certificate Holder or the Certificate Holder's living, covered spouse. 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 Certificate Holder 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 4.7.

4.5 QUALIFIED MEDICAL CHILD SUPPORT ORDERS

This provision applies to Members affected by ERISA. See Section 4.8.

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 Certificate Holder who is recognized under a medical child support order as having a right to enrollment under this Benefit Plan with respect to such Certificate Holder. 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 Certificate Holder 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 Certificate Holder or Member is eligible under the medical plan; and

   2. Clearly specifies:

      a. the name and last known mailing address (if any) of the Certificate Holder 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 Certificate Holder 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 Certificate Holder 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 Certificate Holder 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.

4.6 MEDICAID ELIGIBILITY

This provision applies to Members affected by ERISA. See Section 4.8.

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.

4.7 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 Certificate Holders 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. Certificate Holders should consult their Plan Administrator to find out if and how this provision applies to them and/or their Eligible Dependents.

A Certificate Holder covered by this Benefit Plan may have the right to choose continuation coverage if the Certificate Holder'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 Certificate Holder 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 Certificate Holder;

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

3. Divorce or legal separation; or

4. The Certificate Holder becomes entitled to Medicare benefits.

A dependent child of the Certificate Holder 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 Certificate Holder;

2. The termination of the Certificate Holder'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 Certificate Holder 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 Certificate Holder or is placed for adoption with the Certificate Holder 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 Certificate Holders and their Eligible Dependents under certain conditions. If there is a bankruptcy of the Group, retired Certificate Holders and their Eligible Dependents should contact their Plan Administrator for more information.

The Certificate Holder or the Certificate Holder'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 Certificate Holder 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 Certificate Holder or the Certificate Holder'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 Certificate Holder 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 Certificate Holder's death, termination of employment, reduction in hours or Medicare entitlement, the Plan Administrator will notify the Certificate Holder or Eligible Dependents, as required by law, of the right to choose continuation coverage. The Certificate Holder or Eligible Dependent has 60 days from the date coverage is lost, because of one of the events described above or 60 days from the date the Certificate Holder 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 Certificate Holder or Eligible Dependent does not choose continuation coverage, group coverage will terminate.

If the Certificate Holder 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 Certificate Holder 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 Certificate Holder'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 Certificate Holder 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 Certificate Holder 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 Certificate Holder to choose continuation of coverage. However, under the law a Certificate Holder 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 Certificate Holder 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.

4.8 ERISA RIGHTS

As a Certificate Holder 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 Certificate Holders 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 Certificate Holder 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 Certificate Holders, 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 Certificate Holder 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 Certificate Holder 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 Certificate Holder requests a copy of plan documents or the latest annual report from the Benefit Plan and does not receive them within 30 days, the Certificate Holder 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 Certificate Holder up to $110 a day until the Certificate Holder receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Certificate Holder has a claim for benefits that is denied or ignored, in whole or in part, the Certificate Holder 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 Certificate Holder is discriminated against for asserting their rights, the Certificate Holder may seek assistance from the U.S. Department of Labor, or the Certificate Holder may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Certificate Holder is successful, the court may order the person sued to pay these costs and fees. If the Certificate Holder loses, the court may order the Certificate Holder to pay these costs and fees, for example, if it finds the Certificate Holder's claim frivolous.

E. Assistance with Your Questions.

If the Certificate Holder has any questions about the Benefit Plan, the Certificate Holder should contact the Plan Administrator. If the Certificate Holder has any questions about this statement or about their rights under ERISA, or if the Certificate Holder needs assistance in obtaining documents from the Plan Administrator, the Certificate Holder 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 Certificate Holder may also obtain certain publications about their rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

4.9 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.

4.10 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 Certificate Holder 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, see the Schedule of Benefits.

C. Dental coverage while employed can only be canceled on the Group's Renewal Date.

4.11 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.

4.12 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.

4.13 **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.

4.14 **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 Claims 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.

4.15 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.

4.16 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 4.14 (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{ TC "Section 5 CLAIMS FOR BENEFITS AND APPEALS"\l 1 }

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.

5.1 **APPEALS {** TC "5.1 Appeals"\l 2 **}**

If the Member is dissatisfied with the Claims Administrator's benefit determination on a claim, the Member or the Member's Authorized Representative may appeal the Claims Administrator's decision by following the steps outlined in this procedure. The Claims Administrator will resolve the Member's appeal in a timely manner to ensure that the Member is afforded a full and fair review of claims for benefits. Benefit determinations will be made in accordance with the Plan documents and consistently among claimants. The Member or the Member's Authorized Representative may submit written comments, documents, records and other information relating to claims or appeals. The Claims Administrator will provide a review that takes into account all information submitted whether or not it was considered with its first determination on the claim. Any notifications by the Claims Administrator required under these procedures will be supplied to the Member or the Member's Authorized Representative.

5.2 **PROCEDURE FOR PRESERVICE CLAIMS {** TC "5.2 Procedure For Preservice Claims"\l 2 **}**

The Member or the Member's Authorized Representative has 180 days from the date the Member or the Member's Authorized Representative received notice of the Adverse Benefit Determination to appeal the decision. To file an appeal, call the toll-free telephone number listed in the Benefit Plan or on the Identification Card.

The Dentist advisor involved in the appeal will be different from and not a subordinate of the Dentist advisor involved in the adverse determination on the initial claim for benefits. The Claims Administrator will provide the Member or the Member's Authorized Representative with written or electronic notice of the Claims Administrator's appeal decision within 30 days of the request to review the Adverse Benefit Determination. The notice of the Claims Administrator's appeal decision will include the following:

a. The specific reason for the appeal decision;
b. A reference to specific Plan provisions on which the decision was based;
c. A statement that the Member or the Member's Authorized Representative is entitled reasonable access to and copies of all Relevant documents, records and criteria. This includes an explanation of clinical judgment on which the decision was based and identification of the dental experts. All such information is available upon request and is free of charge.
d. A statement of the Member or the Member's Authorized Representative’s right to bring a civil action under ERISA; and
e. The following statement: "the Member and the Member's Benefit Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and state insurance regulatory agency."

5.3 **PROCEDURE FOR POST-SERVICE CLAIMS {** TC "5.3 Procedure For Post-Service Claims"\l 2 **}**

The Member or the Member's authorized representative may file an appeal with the Claims Administrator within 180 days of receipt of an Adverse Benefit Determination. To file an appeal, call the toll-free number listed in the Benefit Plan or on the Identification Card.

The Claims Administrator will review the claim and notify the Member of the decision within 60 days of the request for appeal. Any Dentist advisor involved in reviewing the appeal will be different from and not in a subordinate position to the Dentist advisor involved in the initial benefit determination.

Notice of the appeal decision will include the following in written or electronic form:

a. the specific reason for the appeal decision;
b. reference to specific Plan provisions on which the decision was based;
c. a statement that the Member is entitled to receive reasonable accessibility to and copies of all Relevant documents, records and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts; All such information is available upon request and is free of charge.
d. a statement of the Member's right to bring a civil action under ERISA; and
e. the following statement "the Member or the Member's Benefit Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and State insurance regulatory agency".

SECTION 6
OTHER PARTY LIABILITY{ TC **"Section 6** OTHER PARTY LIABILITY" \l 1 **}**

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, Certificate Holder, 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, Certificate Holder, 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, Certificate Holder, policyholder or retiree or covering the person as a dependent of an employee, Member, Certificate Holder, 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 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 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 the Claims Administrator 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{ TC "Section 7 DEFINITIONS"\l 1 }

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.

ADVERSE BENEFIT DETERMINATION - is a denial, reduction, or termination of or failure to make payment (in whole or in part) for a claim for benefits based on a determination of eligibility to participate in a plan or the application of any utilization review; or a determination that an item or service otherwise covered is Experimental or Investigational, not Dentally Necessary, not medically necessary or not appropriate.

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 Renewal Date.

ANNUAL MAXIMUM - the greatest amount the Claims Administrator is obligated to pay for all Covered Services rendered during a calendar year or contract year as shown on the Schedule of Benefits.

BENEFIT PERIOD - a specified period of time when benefits are available for Covered Services under this Benefit Plan. A claim 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.

BENEFIT PLAN (PLAN) - the agreement with the Claims Administrator, Including the Certificate Holder's application, Identification Card, the Administrative Service Agreement, this Summary Plan Description and any supplements, endorsements, attachments, addenda or amendments.

CERTIFICATE HOLDER - an individual who, because of his/her status with the Policyholder, has enrolled him/herself and/or his/her Eligible Dependents for dental coverage and for whom Premiums are paid. In the case of the Administrative Service Agreement that covers only dependent children, the Certificate Holder must be the child's or children's parent, stepparent, legal guardian or legal custodian.

CERTIFICATE OF INSURANCE (CERTIFICATE) - this document, Schedule of Benefits, addenda and/or endorsements, if any, which describes the coverage purchased from the Claims Administrator by the Policyholder.

CLAIMS ADMINISTRATOR - Blue Cross Blue Shield of North Dakota, or a third party with which the Blue Cross Blue Shield of North Dakota contracts for a provider network and to perform certain functions to administer the terms of this Benefit Plan. Also referred to as BCBSND.

COINSURANCE - those remaining percentages or dollar amounts of the Maximum Allowable Charge for a Covered Service that are the responsibility of either the Certificate Holder or enrolled Eligible Dependents after the Company pays the percentages or dollar amounts shown on the Schedule of Benefits for a Covered Service.

CONTRACT TYPE - the type of coverage the Certificate Holder is enrolled under, identifying who is eligible to receive benefits for Covered Services under this Benefit Plan. Contract Types are as follows:

A. **Individual Participation**- Certificate Holder only.

B. **Parent and Child Participation** - Certificate Holder and one eligible child.

C. **Parent and Children Participation** - Certificate Holder and eligible children.

D. **Two Person Participation** - Certificate Holder and spouse.

E. **Family Participation** - Certificate Holder and Eligible Dependents.

COSMETIC - services or procedures that are not Dentally Necessary and are primarily intended to improve or otherwise modify the Member's appearance.

COVERED SERVICE - services or procedures shown on the Schedule of Benefits for which benefits will be covered subject to Exclusions and Limitations, when rendered by a Dentist.

DEDUCTIBLE - a specified amount of expenses set forth in the Schedule of Benefits for Covered Services that must be paid by the Member before the Claims Administrator will pay any benefit.

Any Deductible met during the last 3 months of a year is carried forward and applied toward the Deductible for the following year.

DENTALLY NECESSARY - a dental service or procedure is determined by a Dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the Dentist and the prevailing standards of care in the professional community. The determination will be made by the Dentist in accordance with guidelines established by the Claims Administrator. When there is a conflict of opinion between the Dentist and the Claims Administrator on whether or not a dental service or procedure is Dentally Necessary, the opinion of the Claims Administrator will be final.

DENTIST - a person licensed to practice dentistry in the state in which dental services are provided. Dentist will include any other duly licensed dental professional practicing under the scope of the individuals license when state law requires independent reimbursement of such practitioners.

EFFECTIVE DATE - the date on which the Administrative Service Agreement begins or coverage of enrolled Members begins.

ELIGIBLE DEPENDENT - a dependent of the Certificate Holder, or a dependent's dependent (grandchild), who qualifies for membership under this Benefit Plan in accordance with the requirements specified below:

A. The Certificate Holder's spouse under a legally existing marriage.

B. The Certificate Holder or the Certificate Holder's living, covered spouse's children under the age of 26 years. Children are considered under age 26 until the end of the month in which the children become 26 years of age. The term child or children includes:

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

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

3. The Certificate Holder's grandchildren or those of the Certificate Holder's living, covered spouse if: (a) the parent of the grandchild is unmarried, (b) the parent of the grandchild is covered under this Benefit Plan and (c) the parent is primarily dependent on the Certificate Holder 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 Certificate Holder has been appointed legal guardian.

4. Children for whom the Certificate Holder or the Certificate Holder's living, covered spouse 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 Certificate Holder or the Certificate Holder's spouse for support. Coverage for such a disabled child will continue for as long as the child remains unmarried, disabled and the Certificate Holder's dependent for federal income tax purposes. The Certificate Holder may be asked periodically to provide evidence satisfactory to the Claims Administrator of these disabilities.

EXCLUSIONS - services, supplies or charges that are not covered under the Administrative Service Agreement as stated in Section 3, Exclusions.

EXPERIMENTAL OR INVESTIGATIVE - the use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply in which the Claims Administrator in its sole discretion, determines is not acceptable standard dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval which was not granted at the time the services were rendered. The Claims Administrator will rely on the advice of the general dental community including, but not limited to dental consultants, dental journals and/or governmental regulations, to make this determination.

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

IDENTIFICATION CARD - a card issued in the Certificate Holder's name identifying the Unique Member Identifier of the Member.

INCLUDING - means including, but not limited to.

LIFETIME MAXIMUM - the greatest amount the Claims Administrator is obligated to pay for all Covered Services rendered during the entire time the Member is enrolled under the Administrative Service Agreement, as shown on the Schedule of Benefits.

LIMITATION - the maximum frequency or age limit applied to a Covered Service as shown on the Schedule of Benefits.

MAXIMUM ALLOWABLE CHARGE - the maximum amount the Plan will allow for a specific Covered Service. Maximum Allowable Charges may vary depending upon the contract between BCBSND and the Participating Dentist rendering the service. Depending on the Plan purchased by the Policyholder, Maximum Allowable Charges for Covered Services rendered by Nonparticipating Dentists may be the same or higher than charges for Covered Services rendered by Participating Dentists to help limit Out-of-Pocket Expenses of Members choosing Nonparticipating Dentists.

MEMBER - enrolled Certificate Holder and their enrolled Eligible Dependents.

NONPARTICIPATING DENTIST - a Dentist who has not signed a contract with BCBSND to accept the Maximum Allowable Charges as payment in full for Covered Services.

OUT-OF-POCKET EXPENSE - costs not paid by BCBSND, Including, Coinsurance, Deductibles, amounts billed by Nonparticipating Dentists that are over the Maximum Allowable Charge, costs of services that exceed the policy’s Limitations or Maximums or services that are Exclusions. The Certificate Holder is responsible to pay Out-of-Pocket Expenses.

PARTICIPATING DENTIST - a Dentist who has executed a Participating Dentist agreement with BCBSND and agrees to accept BCBSND's Maximum Allowable Charges as payment in full for Covered Services.

POLICYHOLDER - organization that executes the Administrative Service Agreement and that is also the Plan Sponsor and Plan Administrator for purposes of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

POST-SERVICE CLAIM - is any claim for benefits under a group health plan that is not a Preservice Claim.

PRESERVICE CLAIM - is a claim for benefits under the Plan when the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

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.

RELEVANT - a document, record or other information will be considered "relevant" to a given claim:

A. if it was relied on in making the benefit determination;
B. if it was submitted, considered or generated in the course of making the benefit determination (even if the Plan did not rely on it);
C. if it demonstrated that, in making the determination, the Plan followed its own administrative processes and safeguards for ensuring appropriate decision-making and consistency;
D. or if it is a statement of the Plan's policy or guidance concerning the denied benefit, without regard to whether it was relied upon in making the benefit determination.

RENEWAL DATE - the date on which the Administrative Service Agreement renews. Also known as "Anniversary Date".

SCHEDULE OF BENEFITS - attached summary of Covered Services, Coinsurances, Deductibles and maximums applicable to benefits payable under the Plan.

TERMINATION DATE - the date on which the dental coverage ends for a Member or on which the Administrative Service Agreement ends.

UNIQUE MEMBER IDENTIFIER - a number assigned by BCBSND and listed on the Identification Card that identifies the Certificate Holder for administrative purposes.