# CALUMET GP, LLC

**Dental Booklet**

**Plus Plan**

**Revised 10-01-2011**

**BENEFITS ADMINISTERED BY**

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# CALUMET GP, LLC

# GROUP DENTAL BENEFIT PLAN

# SUMMARY PLAN DESCRIPTION

## INTRODUCTION

**Effective: 01-01-2011**

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on benefits available under this Plan, as well as information on a Covered Person's rights and obligations under the CALUMET GP, LLC Dental Benefit Plan (the "Plan"). As a valued Employee of CALUMET GP, LLC, we are pleased to sponsor this Plan to provide benefits that can help meet Your dental care needs.

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

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

The Plan Administrator believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example the elimination of lifetime limits on benefits.

Questions regarding which protection apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at:

CALUMET GP, LLC
2780 WATERFRONT PARKWAY EAST DR
STE 200
INDIANAPOLIS IN 46214
317-328-5660

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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

The requirements for being covered under this Plan, the provisions concerning termination of coverage, description of the Plan benefits (including limitations and exclusions), cost sharing, the procedures to be followed in submitting claims for benefits and remedies available for appeal of claims denied are outlined in the following pages of this document. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions.

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

This document summarizes the benefits and limitations of the Plan and is known as a Summary Plan Description ("SPD"). It is being furnished to You in accordance with ERISA.

This document becomes effective on May 1, 2007.

## PLAN INFORMATION

**Effective: 01-01-2009**

| | |
|---|---|
| **Plan Name** | CALUMET GP, LLC<br>Group Benefit Plan |
| **Name And Address Of Employer** | CALUMET GP, LLC<br>2780 WATERFRONT PARKWAY EAST DR<br>STE 200<br>INDIANAPOLIS IN 46214 |
| **Name, Address And Phone Number Of Plan Administrator** | CALUMET GP, LLC<br>2780 WATERFRONT PARKWAY EAST DR<br>STE 200<br>INDIANAPOLIS IN 46214<br>317-328-5660 |
| **Named Fiduciary** | CALUMET GP, LLC |
| **Employer Identification Number Assigned By The IRS** | 36-4579817 |
| **Plan Number Assigned By The Plan** | 501 |
| **Type Of Benefit Plan Provided** | Self-Funded Health & Welfare Plan providing Group Dental Benefits |
| **Type Of Administration** | The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for dental claims. |
| **Name, Title, And Address Of The Principal Place Of Business Of Each Trustee Of The Plan (If The Plan Has A Trust)** | CALUMET GP, LLC VOLUNTARY EMPLOYEE BENEFICIARY ASSOCIATION<br>2780 WATERFRONT PARKWAY EAST DR<br>STE 200<br>INDIANAPOLIS IN 46214 |
| **Name And Address Of Agent For Service Of Legal Process** | CALUMET GP, LLC<br>2780 WATERFRONT PARKWAY EAST DR<br>STE 200<br>INDIANAPOLIS IN 46214<br><br>Services of legal process may also be made upon the Plan Administrator or plan trustee. |
| **Funding Of The Plan** | Employer and Employee Contributions<br><br>Benefits are provided by a benefit plan maintained on a self-insured basis by Your employer. |

| | |
|---|---|
| **Collective Bargaining Provisions** | The Plan is maintained pursuant to one or more collective bargaining agreements. A copy of the agreements may be obtained upon written request to the Plan Administrator, and such agreements are available for examination. |
| **Benefit Plan Year** | Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year. |
| **ERISA Plan Year** | January 1 through December 31 |
| **ERISA And Other Federal Compliance** | It is intended that this Plan meet all applicable requirements of ERISA and other federal regulations. In the event ERISA or other federal regulations impose any requirement that is inconsistent with this Plan, the provisions of ERISA and the federal regulations shall be deemed controlling, and any inconsistent part of this Plan shall be deemed superseded to the extent of the inconsistency. |
| **Discretionary Authority** | The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, including this Summary Plan Description (SPD), and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrator for this Plan. Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrator shall be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or Third Party Administrator shall be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrator make, in its sole discretion, and further means that the Covered Person consents to the limited standard and scope of review afforded under law. |

## SCHEDULE OF BENEFITS

### Plus Plan

Benefits for You and Your Dependents are listed below.

| **SUMMARY OF BENEFITS**<br><br>**Effective: 01-01-2011** | | |
|---|---|---|
| **Deductibles Per Calendar Year** | Individual | Family |
| • Combined Basic Services and Major Services | $75 | $250 |
| **Deductibles Per Lifetime** | | |
| • Temporomandibular Joint Treatment | $50 | $150 |
| **Maximums** | Individual | |
| • Calendar year Benefit Maximum includes Preventive and Diagnostic Services, Basic Services, and Major Services | $1,500 | |
| • Lifetime Benefit Maximum includes Orthodontic Services, Up to Age 19 | $1,500 | |
| • Lifetime Benefit Maximum includes Temporomandibular Joint Treatment | $1,000 | |
| **Participation Percentage** | **The Plan Pays** | |
| • Preventive and Diagnostic Services | 70% | |
| • Basic Services | 70% | |
| • Major Services | 70% | |
| • Orthodontic Services | 50% | |
| • Temporomandibular Joint Treatment | 70% | |

## OUT-OF-POCKET EXPENSES AND MAXIMUMS

### DEDUCTIBLES

Deductible refers to an amount of money paid once a Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits. The applicable Deductible must be met before any benefits will be paid under this Plan, unless indicated otherwise. A new Deductible must be met each year.

Only Covered Expenses will count toward meeting the Deductible. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

If You have family coverage, any combination of covered family members can help meet the maximum family Deductible, up to each person's individual Deductible amount.

### PLAN PARTICIPATION

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

### ADDITIONAL OUT-OF-POCKET EXPENSES

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

- Any remaining charges due to the provider after the Plan's benefits are determined.
- Full charges for services that are not covered benefits under this Plan.
- Legal fees and interest charged by a provider.

### INDIVIDUAL LIFETIME MAXIMUM BENEFIT

All Covered Expenses will count toward the Covered Person's individual dental Lifetime Maximum Benefit that is shown on the Schedule of Benefits, if applicable.

For Covered Persons who were terminated from the Plan and are later reinstated after a lapse in coverage (for example, a Covered Person ends employment and later is re-hired and re-enrolls in this Plan), the Lifetime Maximum Benefit will not start over. The Lifetime Maximum Benefit will continue to accumulate from the level satisfied at the time of Covered Person's termination.

**NO FORGIVENESS OF OUT-OF-POCKET EXPENSES**

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

## ELIGIBILITY AND ENROLLMENT

**Effective: 01-01-2010**

### ELIGIBILITY AND ENROLLMENT PROCEDURES

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

### ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full time 36 or more hours per week, but for purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

- Temporary or leased employees.
- An Independent Contractor who signs an agreement with the employer as an Independent Contractor or other Independent Contractors as defined in this document.
- A consultant who is paid on other than a regular wage or salary by the employer.
- A member of the employer's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

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

Note: Eligible Employees and Dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential Special Enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for Special Enrollment.

An **eligible Dependent** includes:

- Your legal spouse who is a husband or wife of the opposite sex in accordance with the federal Defense of Marriage Act provided he or she is not covered as an Employee under this Plan. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator.

- A Dependent Child until the Child reaches his or her 20th birthday. The term "**Child**" includes the following Dependents who meet the eligibility criteria listed below:

  - A natural biological Child;
  - A step Child;

- A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 18 as of the date of such placement;
- A Child under Your (or Your Spouse's) Legal Guardianship as ordered by a court;
- A Child who is considered an alternate recipient under a Qualified Medical Child Support Order;

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

**RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS:** The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have a notice obligation to notify the Plan should the Dependent's eligibility status change throughout the Plan year. Please notify Your Human Resources Department regarding status changes.

**Eligibility Criteria:** To be an eligible Dependent Child, the following conditions must all be met:

- A Dependent Child must reside with the Employee. The residency requirement does not apply to Children who are Full-Time Students living away from home to attend school, to Children who reside in an institution, or to Children who are enrolled in accordance with a Qualified Medical Child Support Order because of the Employee's divorce or separation decree.
- A Dependent Child must be dependent upon the Employee for more than 50 percent support and maintenance. The financial requirement does not apply to Children who are enrolled in accordance with a Qualified Medical Child Support Order because of the Employee's divorce or separation decree.
- A Dependent Child must be unmarried.
- A Dependent Child will not be covered if the Child is covered as a Dependent of another Employee at this company.

**EXTENDED COVERAGE FOR DEPENDENT CHILDREN**

Coverage under this Plan may be extended for a Dependent Child if the following conditions are met:

- A covered Dependent Child who is attending high school, a licensed trade school, or an Accredited Institution of Higher Education as a Full-Time Student will continue to be eligible until the end of the month in which the Child turns age 24 or until the Dependent Child no longer attends school as a Full-Time Student, whichever is earlier. Extended coverage for Dependent Children who have not reached age 24 will terminate at the end of the month that the Dependent Child is no longer attending or enrolled as a Full-Time Student. (See below for more information on Loss of Full-Time Student Status due to medical necessity). The Plan may require proof of the Dependent Child's Full-Time Student enrollment on an as-needed basis. A Full-Time Student who finishes the spring term shall be deemed a Full-Time Student throughout the summer if the Student has enrolled as a Full-Time Student for the following fall term, regardless of whether or not such Student enrolls for the summer term.

  A Dependent Child may enroll in the Plan at the beginning of the semester if the Dependent Child qualifies due to initial or re-enrollment as a Full-Time Student. The effective date will be the first of the month following the date he/she returns to school. For the purposes of the Plan, the beginning of the semester is deemed to be August 1 for the fall semester and January 1 for the spring semester; or

- If You have a Dependent Child covered under this Plan who is under the age of 20 and Totally Disabled, either mentally or physically, that Child's dental coverage may continue beyond the day the Child would cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 30 calendar days after the day coverage for the Dependent would normally end. The Plan may, for two years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage can continue subject to the following minimum requirements:

  - The Dependent must not be able to hold a self-sustaining job due to the disability; and
  - Proof must be submitted as required; and
  - The Employee must still be covered under this Plan.

  A Totally Disabled Dependent Child older than 20 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

**Loss of Full-Time Status Due to Medical Necessity**

Dependents who are enrolled in a licensed trade school or an Accredited Institution of Higher Education on the day before the first day of a medically necessary leave of absence or reduction in full-time status will be entitled to up to twelve months of coverage continuation. To qualify:

- The Plan received written certification from the Dependent's treating Physician stating that the Child is suffering from a serious Illness or Injury and that a leave or reduction in enrollment is medically necessary.

- The leave must begin while the Dependent is suffering from a serious Illness or Injury and be medically necessary.

Coverage during a medically necessary leave of absence will be the same as if the Child remained a Full-Time Student and will continue for up to one year from the date the medically necessary leave began or until the Dependent would otherwise lose eligibility under the Plan, whichever is sooner. In addition, if any changes are made to the Plan during the medically necessary leave, the Dependent Child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as Dependent Children are still covered by the Plan.

**IMPORTANT:** It is Your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to attend school as a Full-Time Student for reasons other than minor, short-term Illness or Injury or medical necessity (as described above), or the Dependent does not meet the qualifications of Totally Disabled, the Plan has the right to be reimbursed from the Dependent or Employee for any dental claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Section in this document.

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

**EFFECTIVE DATE OF EMPLOYEE'S COVERAGE**

Your coverage will begin on the later of:

- If You apply within 30 days of hire, Your coverage will become effective the first day of the month coinciding with or following Your date of hire; or

- If You apply after 30 days of hire, You will be considered a Late Enrollee. Coverage for a Late Enrollee will become effective the first day of the month coinciding with or following the date You apply for coverage.

- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 30 days of the event.

**EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS**

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

- The date Your coverage with the Plan begins if You enroll the Dependent at that time; or

- The date You acquire Your Dependent if application is made within 30 days of acquiring the Dependent; or

- The first day of the month coinciding with or following the date an enrollment application is properly made if the Dependent is a Late Enrollee. The Dependent will be considered a Late Enrollee if You request coverage for Your Dependent more than 30 days of Your hire date, or more than 30 days following the date You acquire the Dependent; or

- If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 30 days following the event; or

- The date specified in a Qualified Medical Child Support Order.

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

**ANNUAL OPEN ENROLLMENT PERIOD**

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

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

Annual open enrollment does not apply to Retirees or their Dependents.

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

- The annual open enrollment period shall typically be in the month of November. The employer will give eligible Employees written notice prior to the start of an annual open enrollment period; and

- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and

- The Effective Date of coverage shall be January 1 following the annual open enrollment period.

## SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

**Effective: 04-01-2009**

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

### LOSS OF DENTAL COVERAGE

Current Employees and their Dependents have a special opportunity to enroll for coverage under this Plan if there is a loss of other dental coverage. Loss of other dental coverage triggers special enrollment rights only if other coverage was in effect at the time coverage was declined. The Plan will not recognize a special enrollment right due to a loss of coverage if other coverage was not in effect at the time enrollment was declined. An eligible person declined enrollment if he or she did not enroll in the Plan during the Plan's annual open enrollment period, a special enrollment period or upon COBRA being offered.

You and/or Your Dependents may enroll for dental coverage under this Plan due to loss of dental coverage if the following conditions are met:

- You and/or Your Dependents were covered under a group dental plan or dental insurance policy at the time coverage under this Plan is offered; and

- You and/or Your Dependent stated in writing that the reason for declining coverage was due to coverage under another group dental plan or dental insurance policy; and

- The coverage under the other group dental plan or dental insurance policy was:

    - COBRA continuation coverage and that coverage was exhausted; or
    - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
    - Terminated and no substitute coverage is offered; or
    - Exhausted due to an individual meeting or exceeding a lifetime limit on all benefits; or
    - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 30 calendar days after the date the other coverage ended, or in situations where a Covered Person meets or exceeds a Lifetime limit on all benefits, no later than 30 calendar days after a claim is denied for that reason. The Plan will assume that the written Explanation of Benefits (EOB) form is received five calendar days after the Plan mails the EOB form.

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

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

- Coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact, or

- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

**CHANGE IN FAMILY STATUS**

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

If a person becomes Your eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse and newly acquired Dependent(s) who are not already enrolled, may enroll for dental coverage under this Plan during a special enrollment period. You must request and apply for coverage within 30 calendar days of marriage, birth, adoption or Placement for Adoption.

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

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

**EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION**

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

- In the case of marriage, on the date of the marriage; or
- In the case of a Dependent's birth, on the date of such birth; or
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- You and/or Your Dependents were covered under a Medicaid plan or state child health plan and Your or Your Dependents coverage was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.
- In the case of loss of coverage, on the date following loss of coverage.

**RELATION TO SECTION 125 CAFETERIA PLAN**

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

## TERMINATION

**Effective: 01-01-2010**

Please see the COBRA section of this SPD for questions regarding coverage continuation.

### EMPLOYEE'S COVERAGE

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

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment, or at annual open enrollment periods; or
- The last day of the month in which You are no longer a member of a covered class, as determined by the employer except as follows:
  - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to six months, provided that the applicable Employee contribution is paid when due.
  - If You are temporarily absent from work due to active military duty, refer to USERRA under the USERRA section.
- The last day of the month in which Your employment ends; or
- The date in which You reach Your individual Lifetime Maximum Benefit under this Plan; or
- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan.

### YOUR DEPENDENT'S COVERAGE

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

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends; or
- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the Employee resides; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility section, unless the Child qualifies for Extended Dependent Coverage; or
- If Your Dependent Child qualifies for Extended Dependent Coverage as a Full-Time Student, the last day of the month in which Your Dependent Child no longer qualifies as a Full-Time Student or unless the Dependent Child qualifies for a medically necessary leave of absence (see Extended Dependent Coverage section for more information) the last day of the month Your Dependent Child turns 24, whichever is earlier.

- If Your Dependent Child qualifies for Extended Dependent Coverage as Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or

- The date Dependent coverage is no longer offered under this Plan; or

- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment, or at annual open enrollment periods; or

- The date in which the Dependent reaches the individual Lifetime Maximum Benefit under this Plan; or

- The last day of the month in which the Dependent becomes covered as an Employee under this Plan; or

- The date You or Your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan.

**REINSTATEMENT OF COVERAGE**

If Your coverage ends due to termination of employment, leave of absence or lay-off and You later return to active work within 6 months, You are eligible for coverage on the date of return to active work for this company. If You return to work after the 6 month period, You must meet all requirements of a new Employee. Refer to the information on Family and Medical Leave Act or Uniformed Services Employment and Reemployment Act for possible exceptions, or contact Your Human Resources or Personnel office.

## COBRA CONTINUATION OF COVERAGE

**Effective: 01-01-2009**

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

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

**The COBRA Administrator for this Plan is: UMR**

### INTRODUCTION

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

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

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

### COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

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

If You are an Employee, You will become a Qualified Beneficiary if You lose coverage under the Plan because either one of the following Qualifying Events happens:

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

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

If You are the spouse of an Employee, You will become a Qualified Beneficiary if You lose coverage under the Plan because any of the following Qualifying Events happen:

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

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

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

COBRA continuation coverage for Retired Employees and their Dependents is described below:

| Qualifying Event | Length of Continuation |
|---|---|
| • If You are a Retired Employee and Your coverage is reduced or terminated due to Your Medicare entitlement, and as a result Your Dependent's coverage is also terminated. Your spouse and Dependent Children will also become Qualified Beneficiaries. | up to 36 months |
| • If You are a Retired Employee and Your employer files bankruptcy under Title 11 of the United States Code this may be a Qualifying Event. If the bankruptcy results in Loss of Coverage under this Plan, then the Retired Employee is a Qualified Beneficiary. The Retired Employee's spouse, surviving spouse and Dependent Children will also be Qualified Beneficiaries if bankruptcy results in their Loss of Coverage under this Plan. | |
| ➢ Retired Employee | Lifetime |
| ➢ Dependents | 36 months |

**Effective: 01-01-2009**

## COBRA NOTICE PROCEDURES

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

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

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

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

**Send all notices or other information required to be provided by this Summary Plan Description in writing to:**

**UMR**
**COBRA ADMINISTRATION**
**PO BOX 8046**
**WAUSAU WI 54402-8046**
**Phone Number: (715) 841-2918 or (800) 826-9781 x2918**

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

## COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

### EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

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

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

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

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

## MAKING AN ELECTION TO CONTINUE GROUP DENTAL COVERAGE

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

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

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

## PAYMENT OF CLAIMS

No claims will be paid under this Plan for services that the Qualified Beneficiary receives on or after the date You lose coverage due to a Qualifying Event. If, however, the Qualified Beneficiary decides to elect COBRA continuation coverage, group dental coverage will be reinstated back to the date coverage was lost, provided that the Qualified Beneficiary properly elects COBRA on a timely basis and makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives Your completed COBRA election form and required payment.

## PAYMENT FOR CONTINUATION COVERAGE

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

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

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

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage, however the Qualified Beneficiary will receive specific payment information including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage. Payments postmarked within a 30 day grace period following the due date are considered timely payments.

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

If the COBRA Administrator receives a check that is missing information or has discrepancies regarding the information on the check (i.e., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary and allow him/her 14 days to send in a corrected check. If a corrected check is not received within the 14-day timeframe, then the occurrence will be treated as non-payment and the Qualified Beneficiary(s) will be termed from the Plan in accordance with the plan language above.

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

**A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA**

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

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

- The date any Qualified Beneficiary marries. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.

- The date a Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.

- The date of a final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.

- The date any Qualified Beneficiary becomes covered by another group dental plan.

- Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information within 30 calendar days.

**LENGTH OF CONTINUATION COVERAGE**

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

- For Employees and Dependents. 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children would be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)

- For Dependents only. 36 months from the Qualifying Event if coverage is lost due to one of the following events:

  - Employee's death.
  - Employee's divorce or legal separation.
  - Former Employee becomes enrolled in Medicare.
  - A Dependent Child no longer being a Dependent as defined in the Plan.

- For Retired Employees and Dependents of Retired Employees only. If bankruptcy of the employer is the Qualifying Event that causes Loss of Coverage, the Qualified Beneficiaries can continue COBRA continuation coverage for the following maximum period, subject to all COBRA regulations. The covered Retired Employee can continue COBRA coverage for the rest of his or her life. The covered spouse, surviving spouse or Dependent Child of the covered Retired Employee can continue coverage until the earlier of:

  - The date the Qualified Beneficiary dies; or
  - The date that is 36 months after the death of the covered Retired Employee.

**THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE**

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

**Social Security Disability Determination (For Employees and Dependents)**: A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA. In the event that the Social Security Administration determines the Qualified Beneficiary to be disabled some time before the 60$^{th}$ day of COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

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

The Qualified Beneficiary must give the COBRA Administrator a copy of the Social Security Administration letter of disability determination within 60 days of the later of:

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

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

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

**Second Qualifying Events: (Dependents Only)** If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children if the Employee or former Employee dies, becomes entitled to Medicare (Part A, Part B or both) or is divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent. These events will only lead to the extension when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

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

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

**EARLY TERMINATION OF COBRA CONTINUATION**

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

- The employer ceases to maintain a group dental plan for any Employees. (Note that if the employer terminates the group dental plan that the Qualifying Beneficiary is under, but still maintains another group dental plan for other similarly-situated Employees, the Qualifying Beneficiary will be offered COBRA continuation coverage under the remaining group dental plan, although benefits and costs may not be the same).

- The required contribution for the Qualified Beneficiary's coverage is not paid on time.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled with Medicare.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group dental plan that does not contain any exclusion or limitation with respect to any pre-existing condition(s) for the beneficiary.

- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.

- Termination for cause, such as submitting fraudulent claims.

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

Electing COBRA continuation coverage now may protect some of Your (or Your Dependent's) rights if You or Your Dependent need to obtain an **individual health insurance policy** soon. The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance carriers who offer coverage in the individual market must accept any eligible individuals who apply for coverage without imposing pre-existing condition exclusions, under certain conditions. Some of those conditions pertain to COBRA continuation coverage. To take advantage of this HIPAA right, COBRA continuation coverage under this Plan must be elected and maintained (by paying the cost of coverage) for the duration of the COBRA continuation period. In the event that an individual health insurance policy is needed, You or Your Dependent must apply for coverage with an individual insurance carrier after COBRA continuation coverage is exhausted and before a 63-day break in coverage.

If You or Your Dependent(s) will be obtaining **group health coverage** through a new employer, keep in mind that HIPAA requires employers to reduce pre-existing condition exclusion periods if there is less than a 63-day break in health coverage (Creditable Coverage).

**DEFINITIONS**

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

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

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

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

## UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

### INTRODUCTION

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

### COVERAGE

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

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

### USERRA NOTICE AND ELECTION

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

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

### PAYMENT

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

### EXTENDED COVERAGE RUNS CONCURRENT

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

## PROVIDER NETWORK

**Effective: 01-01-2009**

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

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

**Provider Directory Information**

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

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

www.UMR.com

## PRE-TREATMENT ESTIMATE OF BENEFITS

**Effective: 01-01-2009**

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

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

Getting a Pre-Treatment Estimate of Benefits is recommended whenever the Dentist's estimated charge is $200 or more. This feature is not mandatory; however dental care can be expensive. Covered Persons may want to have an idea how much this dental Plan will pay before agreeing to have the work done.

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

## COVERED EXPENSES

**Effective: 01-01-2010**

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

**General Overview:**

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

## COVERED EXPENSES - PREVENTIVE AND DIAGNOSTIC SERVICES

**Diagnostic Services:**

**Clinical Oral Evaluations**

D0120 Periodic oral evaluation (limited to two per calendar year) (not performed in conjunction with orthodontic treatment)
D0140 Limited oral evaluation - problem focused
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver (limited to two per calendar year) (not performed in conjunction with orthodontic treatment)
D0150 Comprehensive oral evaluation - new or established patient (limited to two per calendar year) (not performed in conjunction with orthodontic treatment)
D0160 Detailed and extensive oral evaluation - problem focused, by report
D0170 Reevaluation - limited, problem focused (Established patient; not post-operative visit) (limited to two per calendar year) (not performed in conjunction with orthodontic treatment)
D0180 Comprehensive periodontal evaluation - new or established patient (limited to two per calendar year) (not performed in conjunction with orthodontic treatment)

**X Rays**

D0210 Intraoral - complete series (including bitewings) (limited to one series every 36 consecutive months, combined with D0330) (a full mouth series includes 4 bitewings and 12 or more periapical x-rays) (not performed in conjunction with orthodontic treatment)
D0220 Intraoral - periapical - first film
D0230 Intraoral - periapical - each additional film (up to 12) (benefits not to exceed a full mouth series)
D0240 Intraoral - occlusal film
D0250 Extraoral - first film
D0260 Extraoral - each additional film
D0270 Bitewing - single film (limited to two visits per year with a maximum of 8 films per visit)
D0272 Bitewing - two films (limited to two visits per year with a maximum of 8 films per visit)
D0273 Bitewing - three films (limited to two visits per year with a maximum of 8 films per visit)
D0274 Bitewing - four films (limited to two visits per year with a maximum of 8 films per visit)
D0277 Vertical bitewings - 7 to 8 films (limited to two visits per year with a maximum of 8 films per visit)
D0290 Posterior - anterior or lateral skull and facial bone survey film
D0310 Sialography
D0330 Panoramic film, including bitewings and periapicals if necessary - (limited to one every 36 consecutive months, combined with D0210) (not performed in conjunction with orthodontic treatment)
D0350 Oral/facial photographic images (includes intraoral and extraoral images) (not performed in conjunction with orthodontic treatment)

**Effective: 01-01-2011**

**Tests and Laboratory Examinations**

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

**Other Diagnostic**

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

**Preventive Services:**

**Cleaning and Fluoride Treatments**

D1110 Prophylaxis - adult - (limited to two per calendar year)
D1120 Prophylaxis - Child - (limited to two per calendar year)
D1203 Topical application of fluoride (prophylaxis not included) - Child - under age 14 (limited to two treatments per calendar year)
D1204 Topical application of fluoride (prophylaxis not included) – Adult through age 13 (limited to two treatments per calendar year)
D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients through 13 years of age (limited to two treatments per calendar year)

**Other Preventive**

D1351 Sealant
D1352 Preventive resin restoration in a moderate to high caries risk patient
D9110 Palliative (emergency) treatment of dental pain - minor procedures - no operative procedures performed
D9230 Analgesia, anxiolysis, inhalation of nitrous oxide

**Space Maintenance** - (passive appliances) - limited to Child –under age 16

D1510 Space maintainer - fixed - unilateral
D1515 Space maintainer - fixed - bilateral
D1520 Space maintainer - removable - unilateral
D1525 Space maintainer - removable - bilateral
D1550 Recementation of space maintainer
D1555 Removal of fixed space maintainer

**Minor Treatment To Control Harmful Habits**

D8210 Removable appliance therapy (not performed in conjunction with orthodontic treatment)
D8220 Fixed appliance therapy (not performed in conjunction with orthodontic treatment)

## COVERED EXPENSES - BASIC SERVICES

**Effective: 01-01-2009**

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

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

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

D2410 Gold foil - one surface
D2420 Gold foil - two surfaces
D2430 Gold foil - three surfaces

**Crowns**

D2799 Provisional crown
D2930 Prefabricated stainless steel crown - primary tooth
D2931 Prefabricated stainless steel crown - permanent tooth
D2932 Prefabricated resin crown
D2933 Prefabricated stainless steel crown with resin window
D2934 Prefabricated esthetic coated stainless steel crown – primary tooth

**Other Basic Restorative Services**

D2910 Recement inlay, onlay or partial coverage restoration
D2915 Recement cast or prefabricated post and core
D2920 Recement crown
D2940 Sedative filling
D2950 Core buildup, including any pins
D2951 Pin retention - per tooth, in addition to restoration
D2970 Temporary crown (fractured tooth)
D6092 Recement implant/abutment supported crown
D6093 Recement implant/abutment supported fixed partial denture
D6973 Core buildup for retainer, including any pins

**Pulp Capping**

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

**Effective: 01-01-2011**

**Pulpotomy**

D3220 Therapeutic pulpotomy - (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament
D3221 Pulpal debridement, primary and permanent teeth

**Endodontic Therapy on Primary Teeth**

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

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

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

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

**Apicoectomy/Periapical Services**

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

**Other Endodontic Procedures**

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

**Surgical Services** (including the usual postoperative services)

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant - limited to four quadrants per Treatment Plan
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant
D4230 Anatomical crown exposure - four or more contiguous teeth per quadrant
D4231 Anatomical crown exposure - one to three teeth per quadrant
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant - limited to four quadrants per Treatment Plan
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant
D4245 Apically positioned flap
D4249 Clinical crown lengthening - hard tissue
D4260 Osseous surgery (including flap entry and closure)- four or more contiguous teeth or bounded teeth spaces per quadrant - limited to four quadrants per Treatment Plan
D4261 Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant
D4263 Bone replacement graft - first site in quadrant
D4264 Bone replacement graft - each additional site in quadrant
D4265 Biologic materials to aid in soft and osseous tissue regeneration
D4266 Guided tissue regeneration - resorbable barrier, per site
D4267 Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)
D4268 Surgical revision procedure, per tooth
D4270 Pedicle soft tissue graft procedure
D4271 Free soft tissue graft procedure (including donor site surgery)
D4273 Subepithelial connective tissue graft procedures, per tooth
D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in same anatomical area)
D4275 Soft tissue allograft
D4276 Combined connective tissue and double pedicle graft, per tooth

**Other Periodontal Services**

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

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

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

**Repairs to Complete Dentures** - Separate benefits are allowed only after six months following installation of denture

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

**Repairs to Partial Dentures**

D5610 Repair resin denture base
D5620 Repair cast framework
D5630 Repair or replace broken clasp
D5640 Replace broken teeth - per tooth

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

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

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

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

**Other Fixed Partial Denture Service**

D6930 Recement fixed partial denture

**Extractions**

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

**Effective: 01-01-2011**

**Surgical Extractions**

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

**Other Surgical Procedures**

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

**Alveoloplasty - Surgical Preparation of Ridge for Dentures**

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

**Vestibuloplasty**

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

**Surgical Excision of Reactive Inflammatory Lesions**

D7410 Excision of benign lesion up to 1.25 cm

**Removal of Tumors, Cysts, and Neoplasms**

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

**Excision of Bone Tissue**

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

**Surgical Incision**

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

**Repair and Suturing**

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

**Other Repair Procedures**

D7951 Sinus augmentation with bone or bone substitutes
D7960 Frenulectomy (frenectomy or frenotomy) - separate procedure
D7963 Frenuloplasty
D7970 Excision of hyperplastic tissue - per arch
D7971 Excision of pericoronal gingiva
D7980 Sialolithotomy
D7983 Closure of salivary fistula

**Anesthesia**

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

**Drugs**

D9610 Therapeutic parenteral drug, single administration

**Miscellaneous Services**

D9930 Treatment of complications (post-surgical) - unusual circumstances, by report

**Major Restorative Dentistry** - Inlay/onlay, crowns and other restorative services are covered only when necessitated by decay or traumatic Injury. Replacement of these services is limited to once every five years. This limitation is not applicable if treatment is the result of Accidental Dental Injury.

**TMJ Radiographs**

D0320 Temporomandibular joint arthrogram, **including** injection
D0321 Other temporomandibular joint films, by **report**
D0322 Tomographic survey

**Inlay/Onlay Restorations**

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

**Crowns**

D2710 Crown - resin-based composite (indirect)
D2712 Crown ¾ resin-based composite (indirect)
D2720 Crown - resin with high noble metal
D2721 Crown - resin with predominantly base metal
D2722 Crown - resin with noble metal
D2740 Crown - porcelain/ceramic substrate
D2750 Crown - porcelain fused to high noble metal
D2751 Crown - porcelain fused to predominantly base metal
D2752 Crown - porcelain fused to noble metal
D2780 Crown - 3/4 cast high noble metal
D2781 Crown - 3/4 cast predominantly base metal
D2782 Crown - 3/4 cast noble metal
D2783 Crown - 3/4 porcelain/ceramic
D2790 Crown - full cast high noble metal
D2791 Crown - full cast predominantly base metal
D2792 Crown - full cast noble metal
D2794 Crown - titanium

**Effective: 01-01-2009**

**Other Restorative Services**

D2952 Post and core in addition to crown, indirectly fabricated
D2953 Each additional indirectly fabricated post - same tooth
D2954 Prefabricated post and core in addition to crown
D2957 Each additional prefabricated post - same tooth
D2960 Labial veneer (laminate) - chairside
D2961 Labial veneer (resin laminate) - laboratory
D2962 Labial veneer (porcelain laminate) - laboratory
D2971 Additional procedures to construct new crown under existing partial denture framework
D2975 Coping
D2980 Crown repair, by report

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

**Complete Dentures**

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

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

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

**Repairs to Partial Dentures**

D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture

**Other Prosthodontic Services**

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

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

D6010 Surgical placement of implant body: endosteal implant
D6012 Surgical placement of interim implant body for transitional prosthesis: endosteal implant
D6040 Surgical placement: eposteal implant
D6050 Surgical placement: transosteal implant
D6053 Implant/abutment supported removable denture for completely edentulous arch
D6054 Implant/abutment supported removable denture for partially edentulous arch
D6055 Dental implant supported connecting bar
D6056 Prefabricated abutment – includes placement
D6057 Custom abutment – includes placement
D6058 Abutment supported porcelain/ceramic crown
D6059 Abutment supported porcelain fused to metal crown (high noble metal)
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061 Abutment supported porcelain fused to metal crown (noble metal)
D6062 Abutment supported cast metal crown (high noble metal)
D6063 Abutment supported cast metal crown (predominantly base metal)
D6064 Abutment supported cast metal crown (noble metal)
D6065 Implant supported porcelain/ceramic crown
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal)
D6068 Abutment supported retainer for porcelain/ceramic FPD
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072 Abutment supported retainer for cast metal FPD (high noble metal)
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074 Abutment supported retainer for cast metal FPD (noble metal)
D6075 Implant supported retainer for ceramic FPD
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
D6078 Implant/abutment supported fixed denture for completely edentulous arch
D6079 Implant/abutment supported fixed denture for partially edentulous arch
D6094 Abutment support crown – (titanium)
D6194 Abutment supported retainer crown for FPD – (titanium)
D7295 Harvest of bone for use in autogenous grafting procedure - per site
D7953 Bone replacement graft for ridge preservation – per site

**Other Implant Services**

D6080 Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis
D6090 Repair implant supported prosthesis, by report
D6095 Repair implant abutment, by report
D6100 Implant removal, by report
D6190 Radiographic/surgical implant index, by report

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

D6205 Pontic - indirect resin based composite
D6210 Pontic - cast high noble metal
D6211 Pontic - cast predominantly base metal
D6212 Pontic - cast noble metal
D6214 Pontic - titanium
D6240 Pontic - porcelain fused to high noble metal
D6241 Pontic - porcelain fused to predominantly base metal
D6242 Pontic - porcelain fused to noble metal
D6245 Pontic - porcelain/ceramic
D6250 Pontic - resin with high noble metal
D6251 Pontic - resin with predominantly base metal
D6252 Pontic - resin with noble metal
D6253 Provisional pontic
D6254 Interim pontic

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

D6545 Retainer - cast metal for resin bonded fixed prosthesis
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis
D6600 Inlay - porcelain/ceramic, two surfaces
D6601 Inlay - porcelain/ceramic, three or more surfaces
D6602 Inlay - cast high noble metal, two surfaces
D6603 Inlay - cast high noble metal, three or more surfaces
D6604 Inlay - cast predominantly base metal, two surfaces
D6605 Inlay - cast predominantly base metal, three or more surfaces
D6606 Inlay - cast noble metal, two surfaces
D6607 Inlay - cast noble metal, three or more surfaces
D6624 Inlay - titanium
D6608 Onlay - porcelain/ceramic, two surfaces
D6609 Onlay - porcelain/ceramic, three or more surfaces
D6610 Onlay - cast high noble metal, two surfaces
D6611 Onlay - cast high noble metal, three or more surfaces
D6612 Onlay - cast predominantly base metal, two surfaces
D6613 Onlay - cast predominantly base metal, three or more surfaces
D6614 Onlay - cast noble metal, two surfaces
D6615 Onlay - cast noble metal, three or more surfaces
D6634 Onlay - titanium
D6710 Crown - indirect resin based composite
D6720 Crown - resin with high noble metal
D6721 Crown - resin with predominantly base metal
D6722 Crown - resin with noble metal
D6740 Crown - porcelain/ceramic
D6750 Crown - porcelain fused to high noble metal
D6751 Crown - porcelain fused to predominantly base metal
D6752 Crown - porcelain fused to noble metal
D6780 Crown - 3/4 cast high noble metal
D6781 Crown - 3/4 cast predominantly based metal
D6782 Crown - 3/4 cast noble metal
D6783 Crown - 3/4 porcelain/ceramic
D6790 Crown - full cast high noble metal
D6791 Crown - full cast predominantly base metal

**Effective: 01-01-2011**

D6792 Crown - full cast noble metal
D6793 Provisional retainer crown
D6794 Crown - titanium
D6795 Interim retainer crown

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

D6940 Stress breaker (only with allowable appliance)
D6970 Cast post and core in addition to fixed partial denture retainer
D6972 Prefabricated post and core in addition to fixed partial denture retainer
D6976 Each additional cast post - same tooth
D6977 Each additional prefabricated post - same tooth
D6980 Fixed partial denture repair, by report
D9120 Fixed partial denture sectioning

## ORTHODONTIC BENEFITS PROVISION

**Effective: 01-01-2011**

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

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

### DEPENDENT CHILD LIMITATION

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

### ORTHODONTIC PROCEDURE

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

### ORTHODONTIC TREATMENT PLAN

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

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

### COVERED ORTHODONTIC EXPENSES

- To be payable, orthodontic treatment must be needed for one or more of the following conditions:
- Overbite or overjet of at least four millimeters; or
- Upper and lower arches in either protrusive or retrusive relation of at least one cusp; or
- Cross-bite; or
- An arch length difference of more than four millimeters in either the upper or lower arch.

## COVERED EXPENSES - ORTHODONTIC

**Effective: 01-01-2011**

**Clinical Oral Evaluations**

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

**Radiographs/Diagnostic Imaging**

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

**Tests and Laboratory Examinations**

D0470 Diagnostic casts (performed in conjunction with orthodontic treatment)

**Other Surgical Procedures**

D7291 Transseptal fiberotomy, supra crestal fiberotomy, by report

**Limited Orthodontic Treatment**

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

**Interceptive Orthodontic Treatment**

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

**Comprehensive Orthodontic Treatment**

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

**Minor Treatment To Control Harmful Habits**

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

**Other Orthodontic Services**

| | |
|---|---|
| D8660 | Pre-orthodontic treatment visit |
| D8670 | Periodic orthodontic treatment visit (as part of contract) |
| D8680 | Orthodontic retention (removal of appliances, construction and placement of retainer(s)) |
| D8690 | Orthodontic treatment (alternative billing to a contract fee) |
| D8691 | Repair of orthodontic appliance |
| D8692 | Replacement of lost or broken retainer (limited to replacement of broken retainer) |
| D8693 | Rebonding or recementing; and/or repair, as required, of fixed retainers |

## COORDINATION OF BENEFITS

**Effective: 01-01-2011**

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

The order of benefit determination rules below determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim. The balance remaining after the Primary Plan's payment, not to exceed the Covered Person's responsibility, is the amount which will be considered in determining the benefits payable under the Secondary Plan. The Deductible or participation amounts, if any, will be applied before benefits are paid on the balance.

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

- Group dental plans, whether insured or self-insured.
- Group health plans, whether insured or self-insured.
- Specific disease policies.
- Foreign policies.
- Medical coverage related to dental care under group or individual automobile policies. See order of benefit determination rules.
- Governmental benefits, including TRICARE, as permitted by law. This does not include Medicaid.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan.

### ORDER OF BENEFIT DETERMINATION RULES

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

- The plan that has no coordination of benefits provision is considered primary.

- When medical payments related to dental care are available under motor vehicle insurance (including No-Fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier.

- The plan that covers the person as an Employee, member or subscriber (that is, other than as a Dependent) is considered primary. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan. Employee plan beneficiaries do not include COBRA Qualified Beneficiaries or retirees.

- The plan that covers a person as a Dependent (or beneficiary under ERISA) is secondary, unless both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent. In that case the plan that covers a person as a Dependent is primary (see continuation coverage below).

- When an individual is covered under a spouse's Plan and also under his or her parent's plan, the Primary Plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the Secondary Plan.

- If one or more plans cover the same person as a Dependent Child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide dental care coverage.
    - If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the Child's dental care expenses or dental care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.

  - If the parents are not married and reside separately, or are divorced or legally separated (whether or not they ever have been married), the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one policy as an active employee (or the dependent of an active employee), and is also covered under another policy as a retired or laid off employee (or the dependent of an active or laid off employee), the policy that covers the person as an active employee (or dependent of an active employee) will be primary.

- Continuation Coverage under COBRA or state law: If a person has elected continuation of coverage under COBRA or state law, and also has coverage under another plan, the continuation coverage is usually secondary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored.

- Longer or Shorter Length of Coverage: The plan that covered the person as an Employee, member, subscriber or retiree longer is primary.

- If an active Employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active Employee, member or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses can be shared equally between the plans. This Plan will not pay more than it would have paid, had it been primary.

**RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

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

**REIMBURSEMENT TO THIRD PARTY ORGANIZATION**

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

**RIGHT OF RECOVERY**

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

## RIGHT OF SUBROGATION, THIRD PARTY LIABILITY AND ASSIGNMENT OF RIGHTS

You, the Covered Person, are being provided benefits pursuant to the Plan implemented by Your employer. This Plan is designed to cover You and Your Dependent(s) with health benefits. This Plan is not intended to serve as a supplement to, or replacement for, any benefits You may recover from any Other Party with respect to any charges Incurred with respect to an Accident, Illness, Injury or other medical condition caused by an act or omission of said Other Party.

For purposes of this section, **Other Party** is defined to include, but is not limited to, the following:

- The party or parties that caused the Accident, Illness, Injury or other medical condition;
- The insurer or other indemnifier of the party or parties who caused the Accident, Illness, Injury or other medical condition;
- The Covered Person's own insurer including, but not limited to, uninsured motorist, underinsured motorist, medical payment or no-fault insurers;
- A worker's compensation or school insurer;
- Any other person, entity, policy or plan that is liable or legally responsible to make payments in relation to the Accident, Illness, Injury or other medical condition.

This section is applicable when a Covered Person and/or his or her Dependent(s) have Incurred charges for an Accident, Illness, Injury or other medical condition for an act or omission of any Other Party which gives the Covered Person and/or his or her Dependent(s) the legal right to seek restitution from such Other Party. In such cases, no benefits shall be due and all claims submitted thereon shall be denied under this Plan unless You, the Covered Person, agree to the following:

- That the Covered Person, or their legal representative, shall notify the Plan of any claim or potential claim the Covered Person and/or their Dependent(s) have against any Other Party within 30 days of the act which gives rise to such claim. That, if requested, the Covered Person or his or her Dependent(s) or legal representative shall supply the Plan with any information that is reasonably necessary to protect the Plan's subrogation interests.

- If such act also results in payments being made under the Plan, that neither the Covered Person nor their Dependent(s) do anything that would prejudice the Plan's rights to recover payments.

- That, if requested, the Covered Person shall enter into a written agreement which shall expressly assign any payments made to them or their Dependent by any Other Party to the Plan, and which shall require them to direct their attorney (and other representatives) in writing to retain separately from any judgment, settlement or otherwise that the attorney or representative receive on the Covered Person's behalf an amount of money sufficient to reimburse the Plan as required by such agreement and to pay such money to the Plan. In the event the Covered Person does not sign or refuses to sign such an agreement, the Plan has no obligation to make any payment for any treatment required as a result of the act or omission of any Other Party. The form of the agreement issued by the Plan for this purpose is expressly incorporated in this Plan and will be provided to the Covered Person at anytime upon request.

- That the Plan is subrogated to all rights they may have, and acknowledge that the Plan will have a first priority lien and right of recovery, on any sum of money received from any Other Party, whether the recovery is by settlement, judgment, mediation, arbitration, or other means.

- That the Plan has a right to recover, either through subrogation, reimbursement or other appropriate equitable relief, the following:

    - Any payments, from the first dollar, that the Covered Person or any other person or organization on behalf of the Covered Person is entitled to receive as a result of the Accident, Illness, Injury or other medical condition, to the full extent of benefits paid or provided by the Plan; and
    - Any overpayments made directly to providers on behalf of the Covered Person for the Accident, Illness, Injury or other medical condition.

- That the Plan's right of recovery shall be in first priority, to the full extent of any and all benefits paid under the Plan, and will not be reduced due to the Covered Person's own negligence or due to the Covered Person not being made whole.

- That the Covered Person shall be solely responsible for all expenses of recovery from any Other Party, including but not limited to all attorney's fees and costs, which amounts will not reduce the amount of reimbursement payable to the Plan under the operation of any common fund doctrines.

- That the Plan will not pay any fees or costs associated with any claim or lawsuit without the Plan's express written consent in advance.

- That the Covered Person or their legal representative or guardian, shall be considered a constructive trustee with respect to any money received from any Other Party in consideration of an Accident, Illness, Injury or other medical condition for which they have received benefits, and that any such funds will be held separate by said trustee until the Plan's lien is addressed.

- The Plan's rights to recovery apply to the Covered Person, to the spouse and Dependent(s) of a Covered Person, COBRA beneficiaries, and any other person who may recover on behalf of a participant, including the Covered Person's estate.

- That the Plan reserves the right to independently pursue and recover paid benefits.

If the Plan has already made payments or provided benefits to You for charges Incurred as a result of an Accident, Illness, Injury or other medical condition for which any Other Party may be liable and You fail to comply with the requirements set forth above, the Plan may reduce future benefits otherwise payable under the Plan for *any* Illness, Injury or medical condition by the amounts recovered by You or Your Dependent(s) from the Other Party.

## GENERAL EXCLUSIONS

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

1. **Acts of War:** Illness or Injury caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

2. **Appointments Missed**: An appointment the Covered Person did not attend.

3. **Athletic Mouth Guards**.

4. **Before Effective Date and After Termination**: Services, supplies or expenses Incurred before coverage begins under this Plan, or after coverage ends are not covered.

5. **Congenital**: Care of a congenital or developmental malformation including congenitally missing teeth.

6. **Cosmetic**: Services or treatment for cosmetic purposes as determined by the Plan, including but not limited to bleaching. This does not apply to Accidental Dental Injury or to orthodontic services.

7. **Criminal Activity**: Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony. The Plan shall enforce this exclusion based upon reasonable information showing that this criminal activity took place.

8. **Denture Duplication**.

9. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical or dental reports and itemized bills.

10. **Employment or Worker's Compensation:** An Illness or Injury arising out of or in the course of any employment for wage or profit, including self-employment, for which the Covered Person was or could have been entitled to benefits under any Worker's Compensation, U.S. Longshoremen and Harbor Worker's or other occupational disease legislation, policy or contract, whether or not such policy or contract is actually in force.

11. **Excess Charges**: Charges or the portion thereof which are in excess of the Usual and Customary charge, the Negotiated Rate or fee schedule.

12. **Experimental or Investigational**: Services, supplies, medicines, treatment, facilities or equipment which the Plan determines are Experimental or Investigational.

13. **Fractures**: treatment of fractures but not including teeth or alveolar process.

14. **Hazardous Hobby:** Care and treatment of an Injury or Illness that results from engaging in a hazardous hobby or activity, except if the Injuries resulted from a medical condition, including a mental/nervous disorder. A hobby or activity is hazardous if it is an unusual activity that is characterized by a constant or increased threat of danger or risk of bodily harm. Examples of hazardous hobbies or activities include but are not limited to participation in: Any kind of organized vehicular motorized speed or endurance contest in the air, on land or water; skydiving; X-games or similar extreme-type competitive events, such as snowboarding, skateboarding, street luge, etc.; mountain climbing, where ropes or guides are customarily used; professional sporting events; hang gliding; unteathered rock climbing; bungee jumping; stunt driving; water or snow ski-jumping, aerobatics contests or demonstrations, and; experimental or ultra light aircraft flying.

15. **Implants** and related services.

16. **Interest and Legal Fees**.

17. **Medications**, whether prescription or over-the-counter, other than those administered while in the Dentist's office as part of treatment.

18. **Military:** A military related Illness or Injury to a Covered Person on active military duty.

19. **Multiple surgical** and periodontal procedures in the same area. Benefits will be limited to the most extensive and inclusive procedure.

20. **Myofunctional Therapy**.

21. **Not Medically Necessary**: Services, supplies, treatment, facilities or equipment which the Plan determines are not Medically Necessary.

22. **Orthodontic Service** unless provided elsewhere in this document.

23. **Orthognathic Surgery** unless provided elsewhere in this document.

24. **Professionally Recognized Standards**: Procedures that are not necessary and do not meet professionally recognized standards of care.

25. **Programs** for oral hygiene or plaque control.

26. **Replacement** of lost, missing or stolen appliances regardless of any other provision of this Plan.

27. **Self-Inflicted** unless due to a medical condition (physical or mental) or domestic violence.

28. **Services At No Charge or Cost**: Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, or which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense code, or as required by law.

29. **Services Provided by a Close Relative.** See Glossary of Terms of this SPD for definition of Close Relative.

30. A **service** not furnished by a Dentist or Dental Hygienist who is acting under a dentist's supervision and direction, unless it is for an x-ray ordered by a Dentist.

31. **Supplies** for plaque control or oral hygiene that can be purchased over-the-counter.

32. **Treatment** for the purpose of altering vertical dimension, restoring occlusion, splinting or replacing tooth structure lost as a result of abrasion, attrition or erosion, unless covered elsewhere in this document.

33. **Benefits not specifically included in the Covered Benefits section of this document are considered excluded**.

# CLAIMS AND APPEAL PROCEDURES

**Effective: 01-01-2009**

## REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures include administrative safeguards and processes that are designed to ensure and verify that benefit claims determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals. UMR will normally send payment for Covered Expenses directly to the Covered Person's provider.

## AUTHORIZED REPRESENTATIVE

**Authorized Representative** means a person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. Minor Dependents must have the signature of a parent or Legal Guardian in order to appoint a third party as an Authorized Representative.

If a Covered Person chooses to use an Authorized Representative, the Covered Person must submit a written letter to the Plan stating the following: The name of the Authorized Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant their Authorized Representative access to their Protected Health Information. This letter must be signed by the Covered Person to be considered official.

## PROCEDURES FOR SUBMITTING CLAIMS

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

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

## PROOF OF LOSS

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the proof of loss period will not be allowed.

## HOW DENTAL BENEFITS ARE CALCULATED

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

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

**Effective: 01-01-2010**

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

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

**Usual and Customary (U&C)** is the amount that is usually charged by dental care providers in the same geographical area for the same services, treatment or materials. An industry fee file is used to determine U&C fee allowances. The U&C level is at the 90$^{th}$ percentile.

**NOTIFICATION OF BENEFIT DETERMINATION**

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

**TIMELINES FOR INITIAL BENEFIT DETERMINATION**

UMR will process a Covered Person's claims within 30 calendar days, but the Plan can have an additional 15 day extension when necessary for reasons beyond control of the Plan if written notice is provided to the Covered Person within the original 30 day period. The Covered Person may voluntarily extend these timelines.

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

**CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS**

Claims can be denied for any of the following reasons:

- Termination of Your employment.
- Covered Person is no longer eligible for coverage under the dental Plan.
- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group dental Plan.
- Termination of the group dental Plan.
- Employee, Dependent or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations or penalties.

- Application of the Usual and Customary fee limits, fee schedule or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this SPD.

## ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

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

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

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

## APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

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

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

- Covered Persons must file the appeal within 180 days of the date they received the Explanation of Benefits (EOB) form from the Plan showing that the claim was denied. The Plan will assume that Covered Persons received the written EOB form five days after the Plan mailed the EOB form.
- Covered Persons or their Authorized Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Covered Persons may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.

- If the benefit denial was based in whole or in part on a dental judgment, the Plan will consult with a dental care professional with training and experience in the relevant dental field. This dental care professional may not have been involved in the original denial decision, nor be supervised by the dental care professional who was involved. If the Plan has obtained dental or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, Covered Persons will receive written notification letting them know if the claim is being approved or denied. The notification will provide Covered Persons with the information outlined under the Adverse Benefit Determination section above. It will also notify them of their right to file suit under ERISA after they have completed all mandatory appeal levels described in this SPD.

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

- Covered Persons who are not satisfied with the decision following the first appeal, have the right to appeal the denial a second time.
- Covered Persons or their Authorized Representative must submit a written request for a second review within 60 calendar days following the date they received the Plan's decision regarding the first appeal. The Plan will assume that Covered Persons received the determination letter regarding the first appeal five days following the date the Plan sends the determination letter.
- Covered Persons may submit written comments, documents, records and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based in whole or in part on a dental judgment, the Plan will consult with a dental care professional with training and experience in the relevant dental field. This dental care professional may not have been involved in the original denial decision or first appeal, nor be supervised by the dental care professional who was involved. If the Plan has obtained dental or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting them know if the claim is being approved or denied. The notification will provide the Covered Person with the information outlined under the Adverse Benefit Determination section above. It will also notify them of their right to file suit under ERISA after they have completed all mandatory appeal levels described in this SPD.

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

**Effective: 01-01-2011**

**Appeals should be sent within the prescribed time period as stated above to**:

Send first level Dental appeals to:
UMR
CLAIMS APPEAL UNIT
PO BOX 8086
WAUSAU WI 54402-8086

Send second level Dental appeals to:
CALUMET GP, LLC
2780 WATERFRONT PARKWAY EAST DR
STE 200
INDIANAPOLIS IN 46214

**TIME PERIODS FOR MAKING DECISION ON APPEALS**

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide it to You free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

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

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

**LEGAL ACTIONS FOLLOWING APPEALS**

After completing all mandatory appeal levels through this Plan, Covered Persons have the right to further appeal Adverse Benefit Determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the ERISA Statement of Rights section of this SPD for more details. No such action may be filed against the Plan after three years from the date the Plan gives the Covered Person a final determination on their appeal.

**RIGHT TO REQUEST OVERPAYMENTS**

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

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

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

## FRAUD

**Effective: 01-01-2011**

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

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

Covered Persons must:

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

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

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

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

## OTHER FEDERAL PROVISIONS

**Effective: 01-01-2010**

### FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

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

Coverage will be continued for up to the greater of:

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

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

### QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

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

The order must clearly identify all of the following:

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

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

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

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

## HIPAA ADMINISTRATIVE SIMPLIFICATION
## MEDICAL PRIVACY AND SECURITY PROVISION

This Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These modifications have or will become effective as required by applicable provisions of the Privacy and Security Regulations.

First, under HIPAA Privacy Regulations, this Plan has been modified to allow the Disclosure of Protected Health Information (PHI), as defined under HIPAA, to the Plan Sponsor. The USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA section of this document specifies the terms under which the Plan may share PHI with the Plan Sponsor and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan agrees that it will only disclose a Covered Person's PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms contained in the USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA section have been adopted and the Plan Sponsor agrees to abide by these terms.

The HIPAA Privacy Regulation provision of this Plan took effect April 14, 2003.

Second, under HIPAA Security Regulations, this Plan has been modified to require the Plan Sponsor to reasonably and appropriately safeguard Electronic Protected Health Information (Electronic PHI), as defined under HIPAA, created, received, maintained or transmitted to or by the Plan Sponsor on behalf of this Plan.

Modifications made for the HIPAA Security Regulations are effective as of April 21, 2005 and can be identified in this provision by reference to Security Regulations or Electronic PHI.

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

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

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

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

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

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

- The Plan Sponsor will only use and disclose a Covered Person's PHI (including Electronic PHI) for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI to agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any security incident with respect to Electronic PHI of which Plan Sponsor becomes aware;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Covered Persons have a right to see the disclosure log. The Plan Sponsor does not have to maintain a log if disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books and records relating to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

**DEFINITIONS**

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

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

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

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

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

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

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

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

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical (or dental) review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;

- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

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

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

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

**Plan Sponsor** means Your employer.

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

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

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

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

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

## STATEMENT OF ERISA RIGHTS

Covered Persons under this group dental Plan, are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to:

### RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

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

- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report (Form 5500 series). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### CONTINUE GROUP DENTAL COVERAGE

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

### PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

### NO DISCRIMINATION

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

## ENFORCING COVERED PERSONS' RIGHTS

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

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

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

## ASSISTANCE WITH QUESTIONS

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

## PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part (and with respect to any class of Employees, Retirees or Dependents), including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material changes to the Plan.

### COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

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

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination.

The Plan will assume that the Covered Person received the written amendment or termination letter from the Plan Administrator five days after the letter is mailed to the Covered Person regarding the changes.

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

### NO CONTRACT OF EMPLOYMENT

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

## GLOSSARY OF TERMS

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

**Accredited Institution of Higher Education** means, for the purposes of this Plan, a two-year or four-year college or university or licensed trade school.

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

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

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

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

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

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

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

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

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

**Dependent** – see Eligibility and Enrollment section of this SPD.

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

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

**Employee** – see Eligibility and Enrollment section of this SPD.

**Enrollment Date** means:

- For anyone who applies for coverage when first eligible, the Enrollment Date is the date that coverage begins, or if there is a Waiting Period, the first day of the Waiting Period, whichever is earlier.
- For anyone who enrolls on a Special Enrollment date, the Enrollment Date is the first day of coverage.
- For Late Enrollees, the Enrollment Date is the first day of coverage.

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

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

- Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);

- Items that do not have strong research-based evidence of safety and efficacy to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;

- Items based on anecdotal and Unproven evidence of safety and efficacy (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;

- Items which have been identified through research-based evidence of safety and efficacy to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

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

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

**Full-Time Student or Student** means a Student attending high school or an accredited 2- or 4-year college or university and which is accredited in the current publication of Accredited Institutions of Higher Education or a licensed trade school. Students attending a combination of accredited institutions and whose total combined attendance meets the requirements listed in this paragraph also will qualify as Full-Time Students. Attendance is based on what the accredited school considers to be full-time. If a Student is attending a combination of accredited schools, Full-Time status will be determined after reviewing what each school considered to be Full-Time, or a minimum of 12 credits.

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

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

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

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

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

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

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

**Lifetime Maximum Benefit** means the maximum amount of Covered Benefits payable while a person is covered under this Plan. When the Lifetime Maximum Benefit is met, a Covered Person is no longer eligible for benefits under this Plan. Lifetime does not mean during the lifetime of the Covered Person.

**Maximum Benefit** means the maximum amount to be paid by the Plan on behalf of the Covered Person for Covered Expenses which are Incurred while the person is covered under the Plan.

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

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

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

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

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

**Qualified** means licensed, registered or certified by the state in which the provider practices.

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

**Plan** means CALUMET GP, LLC Group Dental Benefit Plan.

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

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

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

**Retired Employee (Retiree)** means a person who was employed full time by the employer who is no longer regularly at work and who is now retired under the employer's formal retirement program.

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

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

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is qualified by education, training or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.
- Diagnosis of one or more of the following conditions is not considered proof of Total Disability. Conditions are listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) in the following categories:

    - Organic psychotic disorders, or
    - Personality disorders, or
    - Sexual/gender identity disorders, or
    - Behavior and impulse control disorders, or
    - “V” codes.

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

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

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

**You, Your** means the Employee.