

ROYAL NEIGHBORS OF AMERICA ROCK ISLAND IL

**Dental Benefit Summary Plan Description
7670-02-030038**

Revised 01-01-2022

BENEFITS ADMINISTERED BY



A UnitedHealthcare Company

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ROYAL NEIGHBORS OF AMERICA

GROUP DENTAL BENEFIT PLAN

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on Your benefits along with information on Your rights and obligations under this Plan. As a valued employee of ROYAL NEIGHBORS OF AMERICA, we are pleased to provide You with benefits that can help meet Your dental care needs.

ROYAL NEIGHBORS OF AMERICA 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 employee benefits out of general assets, however employees help cover some of the costs of covered benefits through premiums, Deductibles, and 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:

ROYAL NEIGHBORS OF AMERICA
230 16TH ST
ROCK ISLAND IL 61201
(309) 788-4561.

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. When reading this document, please refer to the Glossary of Terms. Becoming familiar with the terms defined in the Glossary will help You better understand the provisions of this group dental plan.

The requirements for being covered under this Plan, the provisions concerning termination of coverage, a 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 booklet. Please read this document carefully and contact Your Human Resources department if You have questions.

If You haven't already received an Identification Card, You will be getting a card soon that You should present to the provider when You receive services. This card also has phone numbers on the back of the card so You know who to call if You have questions or problems.

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

This document becomes effective on January 1, 2004.

PLAN INFORMATION

Plan Name	ROYAL NEIGHBORS OF AMERICA GROUP BENEFIT PLAN
Name and Address of Employer	ROYAL NEIGHBORS OF AMERICA 230 16 TH ST ROCK ISLAND IL 61201
Name, Address and Phone Number Of Plan Administrator	ROYAL NEIGHBORS OF AMERICA 230 16 TH ST ROCK ISLAND IL 61201 (309) 788-4561
Named Fiduciary	Plan Administrator
Employer identification number assigned by the IRS	36-1711198
Plan number assigned by the Plan	502
Type of Benefit Plan Provided	Self-Funded Health & Welfare Plan providing Group Dental Benefits
Type of Administration	The Plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the employer's dental benefits plan. It 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 and enrollment.
Name and Address of Agent for Service of Legal Process	RONDI DOYLE ROYAL NEIGHBORS OF AMERICA 230 16 TH ST ROCK ISLAND IL 61201 (309) 788-4561 Services of legal process may also be made upon the Plan Administrator.
Funding of the Plan	Employer and Employee Contributions Benefits are provided by a benefit plan maintained on a self-insured basis by Your employer.
Benefit Plan Year	Benefits begin on 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 of any conflict between this Plan and ERISA or other federal regulations, the provisions of ERISA and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, 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 Administrators for this Plan. Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrators shall be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator or Third Party Administrators shall be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators 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 Administrators make, in its sole discretion, and further, constitutes agreement to the limited standard and scope of review described by this section.

SCHEDULE OF BENEFITS

Benefit Plan 001

Benefits for You and Your Dependents are listed below.

SUMMARY OF BENEFITS	
Deductibles per Calendar year <ul style="list-style-type: none"> Combined Basic Services, Major Services and Orthodontic Services 	<div>Individual</div> <div>\$50</div> <div>Family</div> <div>\$100</div>
Maximums <ul style="list-style-type: none"> Calendar year Benefit Maximum includes Preventive and Diagnostic Services, Basic Services, and Major Services <ul style="list-style-type: none"> Lifetime Orthodontic Maximum Dependent Children Only 	<div>Individual</div> <div>\$1,250</div> <div>\$1,250</div>
Participation Percentage: <ul style="list-style-type: none"> Preventive Services And Diagnostic Services (Deductible Waived): Routine Cleanings, Fluoride Treatments, And Sealants. Oral Exams And Bitewing And Full-Mouth X-Rays. Refer To Covered Expenses For Any Limitations. Basic Services: Fillings, Endodontics, Periodontics, And Oral Surgery. Refer To Covered Expenses For Any Limitations. Major Services: Inlays, Onlays And Crowns, Bridges, Dentures. Refer To Covered Expenses For Any Limitations. Orthodontic Services: Orthodontic Diagnosis, Treatment, And Appliances. Refer To Covered Expenses For Any Limitations. 	<div>The Plan Pays</div> <div>100%</div> <div>80%</div> <div>50%</div> <div>50%</div>
Participation Percentage: <ul style="list-style-type: none"> Preventive Services And Diagnostic Services (Deductible Waived): Routine Cleanings, Fluoride Treatments, And Sealants. Oral Exams And Bitewing And Full-Mouth X-Rays. Refer To Covered Expenses For Any Limitations. 	<div>The Plan Pays</div> <div>100%</div>

SUMMARY OF BENEFITS	
<ul style="list-style-type: none"> • Basic Services: Fillings, Endodontics, Periodontics, And Oral Surgery. Refer To Covered Expenses For Any Limitations. • Major Services: Inlays, Onlays And Crowns, Bridges, Dentures. Refer To Covered Expenses For Any Limitations. • Orthodontic Services: Orthodontic Diagnosis, Treatment, And Appliances. Refer To Covered Expenses For Any Limitations. 	<p>80%</p> <p>50%</p> <p>50%</p>
Limitations and Exclusions: Refer To General Exclusions.	<p>Not Payable</p>

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.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

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

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

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

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 change 30 or more hours per week or part-time 25 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:

- Leased Employees.
- A consultant who is paid on other than a regular wage or salary by the employer.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. Employees who meet eligibility requirements during a measurement period as required by the Affordable Care Act (ACA) regulations will have been deemed to have met the eligibility requirements for the resulting stability period as required by the ACA regulations. 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, will 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.
- Your Domestic Partner, so long as he or she meets the definition of Domestic Partner as stated in the Glossary of Terms, and the person is not covered as an Employee under this Plan. When a person no longer meets the definition of Domestic Partner, that person no longer qualifies as Your Dependent
- A Dependent Child until the Child reaches his or her 26th birthday. The term "**Child**" includes the following Dependents:
 - A natural biological child;
 - A step child;

- A legally adopted child or a child legally Placed for Adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the child has not attained age 26 as of the date of such placement;
- A child under Your (or Your Spouse's Legal Guardianship as ordered by a court;
- A child who is considered an alternate recipient under a Qualified Medical Child Support Order;
- A Dependent does not include the following:
 - A child who is under the age of 26, who is eligible for group health benefits under his or her employer or his or her spouse's employer;
 - A Dependent child if the child is covered as a Dependent of another Employee at this company.

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

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

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

RIGHT TO CHECK A DEPENDENT'S 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.

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 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 date You apply for coverage. (Persons who apply under the Special Enrollment provision are not considered Late Enrollees).
- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 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 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.

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 December. 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

TERMINATION

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 day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment, or at annual open enrollment periods; or
- The end of the stability period in which You became a member of a non-covered class, as determined by the employer except as follows:
 - If **disabled**, Your coverage under this Plan will continue **until the plan holder tells the Plan to cancel Your coverage, but no more than 3 months from the date Your coverage would otherwise end**, provided that the applicable Employee contribution is paid when due.
 - If **laid-off**, Your coverage under this Plan will continue **until the end of the month following the month in which You are laid-off**, provided that the applicable Employee contribution is paid when due.
 - If **granted a** leave of absence, Your coverage under this Plan will continue **until the plan holder tells the Plan to cancel Your coverage**, 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 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 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 day of the month in which Your Dependent no longer qualifies as a Domestic Partner; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility section, or

- The date Dependent coverage is no longer offered under this Plan; or
- The 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 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 and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 13-week period, You will be treated as a new hire and will be required to meet all the requirements of a new Employee.

If Your coverage ends due to termination of employment, leave of absence or lay-off and You later return to active work, 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.

EXTENSION OF BENEFITS

No benefits shall be paid after coverage terminates except as provided below:

- Benefits shall be paid for Covered Expenses before the termination of coverage;
- Benefits shall be paid for Covered Expenses within 90 days after the termination of coverage for:
 - An appliance or change of appliance (excluding active or passive orthodontic appliances), if the master impression has been made prior to termination; and
 - A crown, bridge or cast restoration, if the tooth or teeth have been prepared prior to termination; and
 - Root canal therapy, if the pulp chamber has been opened prior to termination.

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

LOSS OF DENTAL COVERAGE

If You or Your Dependents lose other dental insurance or group dental coverage and are otherwise eligible under this Plan, and did not enroll when first eligible because You or Your Dependents had other dental coverage; then You and/or Your Dependents may enroll for dental coverage under this Plan, but only if the following conditions are met:

- You and/or Your Dependents were covered under a group dental plan or dental insurance at the time coverage under this Plan was first 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; and
- The coverage under another group dental plan or dental insurance was:
 - Under a federal COBRA continuation provision and that coverage was exhausted; or
 - Under another type of coverage and that coverage terminated as a result of:
 - Loss of eligibility for the coverage due to legal separation, divorce, death, termination of employment or reduction in the number of hours of employment; or
 - The current or former employer no longer contributes towards the coverage; and
 - Under either (1) or (2) above, the coverage was not terminated due to the person's failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact; and
- 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.
- 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.

CHANGE IN FAMILY STATUS

If a person becomes Your Eligible Dependent through marriage, birth, adoption or Placement for Adoption, and You or Your Dependents did not have other dental coverage as listed above; and are otherwise eligible under this Plan; and did not enroll when first eligible, then the Plan will provide for a special enrollment period as described below.

The employee, spouse and newly acquired Dependent, 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 days of marriage, birth, adoption or Placement for Adoption. (Other Dependents, such as siblings of a newborn or adopted child are not entitled to special enrollment rights upon the birth or adoption of a child).

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 You properly apply 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
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the date the approved request for coverage is received; or
- In the case of loss of coverage, on the date following loss of coverage.

RELATION TO SECTION 125 CAFETERIA PLAN

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

COBRA CONTINUATION OF COVERAGE

Important. Read this entire provision to understand Your COBRA rights and obligations.

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

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

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 triggers 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.

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
• 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 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 NOTICE PROCEDURES

ABOUT THE NOTICE(S) YOU ARE REQUIRED TO PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

To be eligible to receive COBRA continuation coverage, covered Employees and Qualified Beneficiaries have certain obligations to provide written notices to the administrator. You should 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 Your 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.

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

**UMR
COBRA ADMINISTRATION
PO BOX 1206
WAUSAU WI 54402-1206
Phone Number: (715) 841-2918 or (800) 207-1824**

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

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

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

EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

You must give notice 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 covered under a plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to Your employer in order to ensure rights to COBRA continuation coverage. You must provide this notice within the 60-calendar day period that begins on the latest of:

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

Once You have provided notice of the Qualifying Event, then Your employer will notify the COBRA Administrator within 30 calendar days from that date.

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 YOUR GROUP DENTAL COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. You will receive a COBRA Election Form that You must complete if You wish to elect to continue Your group dental coverage. 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 You do not choose COBRA continuation coverage within the 60-day election period, Your group dental coverage will end on the day of Your Qualifying Event.

PAYMENT OF CLAIMS

No claims will be paid under this Plan for services that You receive on or after the date You lose coverage due to a Qualifying Event. If, however, You decide to elect COBRA continuation coverage, Your group dental coverage will be reinstated back to the date You lost coverage, provided that You properly elect COBRA on a timely basis and make 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 Your coverage under the Plan would have otherwise terminated, up to the time You make the first payment. If the initial payment is not made within the 45-day period, then Your 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 You will receive specific payment information including due dates, when You become eligible for and elect 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 You 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 terminated 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.

YOUR 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 gets married. Refer to the Special Enrollment section of this Plan 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 Plan 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.
- The date the COBRA Administrator or the Plan Administrator requests additional information from You. You 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.
- 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.
 - A Dependent child no longer being a Dependent as defined in the Plan.

YOUR RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

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

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

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

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

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

You must provide the notice of a second Qualifying Event 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; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

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

In general, if You do not enroll in Medicare Part A or B when You are first eligible because You are still employed, after the Medicare initial enrollment period You have an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of (a) the month after Your employment ends, or (b) the month after group health plan coverage based on current employment ends.

If You do not enroll in Medicare and elect COBRA continuation coverage instead, You may have to pay a Part B late enrollment penalty and You may have a gap in coverage if You decide You want Part B later. If You elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate Your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if You enroll in the other part of Medicare after the date of the election of COBRA coverage. If You are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (as the primary payer) and COBRA continuation coverage will pay second. For more information visit <https://www.medicare.gov/medicare-and-you>.

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 You are under, but still maintains another group dental plan for other similarly-situated Employees, You 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 covered under another group dental plan.
- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.
- Termination for cause, such as submitting fraudulent claims.

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

If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose his or her special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary as it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with his or her HIPAA special enrollment rights.

DEFINITIONS

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

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

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

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

IF YOU HAVE QUESTIONS

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

The Plan Administrator:
ROYAL NEIGHBORS OF AMERICA
230 16TH ST
ROCK ISLAND IL 61201

The COBRA Administrator:
UMR COBRA ADMINISTRATION
PO BOX 1206
WAUSAU WI 54402-1206

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 (PPO's)

The word "**Network**" means an outside organization that has contracted with various providers to provide dental care services to Covered Persons at negotiated fees. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Participation amounts or other out-of-pocket expenses. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing which Network a provider belongs to will help a Covered Person determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons need to see an In-Network provider, however this Plan does not limit a Covered Person's right to choose his or her own provider of dental care at his or her own expense if a dental expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

A provider may enter into an agreement to provide only certain covered dental services, but not all covered dental services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the covered dental services and products included in the participation agreement, and a non-Network provider for other covered dental services and products. The participation status of providers may change from time to time.

To find out which Network a provider belongs to, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

The Preferred Provider Organization is UnitedHealthcare Dental PPO Network.

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 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 can give the Plan Administrator a written request. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

Information on participating providers can also be accessed at the following website:

www.UMR.com

ALTERNATE BENEFITS PROVISION

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

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

PRE-TREATMENT ESTIMATE OF BENEFITS

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

Usually, before beginning any extensive treatment, You 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 You and the Dentist, in advance, regarding what benefits are payable under Your dental Plan, and how much You 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. You may want to have an idea how much Your dental Plan will pay before You agree 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

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.

PREVENTIVE SERVICES

- Cleanings (routine prophylaxis) – limited to two per calendar year.
- Topical fluoride treatments - covered for Dependent Children under the age of 19 only. Limited to one treatment every 12 consecutive months. A cleaning performed with a fluoride treatment is a separate dental service.

DIAGNOSTIC SERVICES

- Oral exams - limited to two per calendar year.
- Full-mouth X-rays - limited to one every 36 consecutive months, unless necessary due to an Injury,.
- Panoramic / panorex X-rays - limited to one every 36 consecutive months, unless necessary due to an Injury.
- Bitewing X-rays - limited to two visits per calendar year.
- Ancillary - emergency oral exams and palliative treatment for relief of dental pain.
- X-rays - all other dental X-rays when Medically Necessary as part of the treatment of a Covered Expense.

Temporomandibular Joint Disorder

- Treatment of disturbances of the temporomandibular joint.
- Arthrogram, including injection.
- Other temporomandibular joint radiographic images, by report.
- Tomographic survey.
- Noninvasive physical therapies.

BASIC SERVICES

An alternate benefit may apply to specific services, refer to the Alternate Benefits section in this SPD for more details.

- Space maintainers - fixed appliances to maintain a space created by the premature loss of a primary tooth or teeth.
- Sealants - covered for Dependent Children the age of 15 only. Limited to permanent molar teeth only once per lifetime. Not covered for primary teeth.
- Restorative fillings – amalgam, silicate, acrylic, synthetic porcelain, and composite fillings.

- Preformed stainless steel crowns – limited to Dependent Children with deciduous primary teeth only.
- Endodontics – root canal treatments, root canal fillings, pulp vitality tests, and other related procedures.
- Periodontics – debridement and exams and other related procedures necessary to treat a disease of the supporting tissues of the teeth. Periodontal splinting is not a covered expense.
- Periodontal maintenance - limited to one treatment every three consecutive months.
- Occlusal guard - (only in conjunction with periodontal surgery or bruxism - limited to one every five years).
- Occlusal adjustment - (only in conjunction with periodontal surgery or bruxism - limited to four quadrants per Treatment Plan).
- Oral surgery – extractions and other oral surgery including preoperative and postoperative care.
- Local anesthesia when Medically Necessary.
- General anesthesia – when administered by a Dentist due to oral or dental surgery when Medically Necessary.
- Rebase procedures for denture or bridges. Not covered during the first six months after initial placement.
- Reline procedures for dentures or bridges – limited to one every 60 consecutive months. Not covered during the first six months after initial placement.

MAJOR SERVICES

An alternate benefit may apply to specific services. Refer to the Alternate Benefits section in this SPD for more details.

The alternate benefit of a filling may be applied if there is not enough evidence to support major decay or traumatic Injury.

If two or more teeth are missing in the same arch or two or more bridges are being performed in the same arch, an alternate benefit of a partial denture may be applied.

- Inlays or onlays.
- Crowns.
- Installation of removable or fixed bridgework.
- Installation of partial and complete dentures, including six-month post-installation care.

Replacement of a bridge or denture will be covered only if the appliance was installed at least five years prior to its replacement. This provision will not apply if:

- Replacement is Medically Necessary due to the placement of an initial opposing full denture;
- Replacement is Medically Necessary due to the extraction of additional natural teeth. Such extraction must leave the bridge or partial denture unserviceable;

- The bridge or denture is damaged beyond repair while in the oral cavity. The Injury must occur while You are covered under this Plan; or
- The existing denture is a temporary denture, placed while You were covered under this Plan. Replacement by a permanent denture must be required and performed within 12 months of the date the temporary denture was placed.

Expenses Incurred for prosthodontic services performed on teeth other than permanent teeth are not covered.

Expenses Incurred at any time to replace a bridge or denture that meets, or can be made to meet, commonly held dental standards of functional acceptability are not covered.

The initial installation of a bridge or denture, replacing natural teeth that were extracted prior to Your effective date, is not covered. Such installation will be covered if Medically Necessary due to the loss or extraction of additional natural teeth after Your effective date.

ORTHODONTIC BENEFITS PROVISION

The Plan will pay Covered Expenses for Orthodontic Procedures as listed under the Covered Expenses for the Covered Person. This benefit is subject to Medical Necessity and all other Plan provisions.

With respect to each Covered Person, the Maximum Benefit payable under this Provision for all Covered Orthodontic Expenses during the Covered Person's lifetime 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.

COORDINATION OF BENEFITS

This Coordination of Benefits (COB) provision applies whenever a Covered Person has dental coverage under more than one Plan, as defined below. It does not, however, apply to prescription benefits. In addition, if the same dental procedure is covered under both Your health plan and dental plan, Your health plan with this company will pay benefits first. 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 Your claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses incurred. Up to total of 100% of charges incurred may be paid between the plans.

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

- Group dental plans, whether insured or self-insured.
- Group health plans, whether insured or self-insured.
- Specific disease policies.
- Foreign policies.
- Medical coverage related to dental care under group or individual automobile policies. See order of benefit determination rules and General Exclusions: No-Fault State for details
- Governmental benefits, including TRICARE, as permitted by law. This does not include Medicaid.
- This Plan does not, however, coordinate benefits with individual health or dental plans.

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

ORDER BENEFIT OF 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. See General Exclusions – No-Fault State in this SPD for more details.
- 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.

TRICARE

If an eligible Employee is on active military duty, TRICARE is the only coverage available to that Employee. Benefits are not coordinated with the Employee's health insurance plan.

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

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

RIGHT OF RECOVERY

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

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET PROVISION

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

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

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

The following persons and entities are considered third parties:

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

You agree as follows:

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

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

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

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

GENERAL EXCLUSIONS

The Plan does not pay for expenses incurred for the following, even if deemed to be Medically Necessary, unless otherwise stated below.

1. **Acts of War:** Injury or Illness 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. [This does not apply to Orthodontic Services.](#)
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:** [Injury while committing or attempting to commit a felony or engaging in an illegal occupation.](#)
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. **Experimental or Investigational:** Services, supplies, medicines, treatment, facilities or equipment which the Plan determines are Experimental or Investigational.
12. **Fractures:** treatment of fractures but not including teeth or alveolar process.
13. **Implants** and related services.
14. **Interest and legal fees.**
15. **Medications,** whether prescription or over-the-counter, other than those administered while in the Dentist's office as part of treatment.
16. **Military:** A military related injury to a Covered Person on active military duty.
17. **Multiple surgical** and periodontal procedures in the same area. Benefits will be limited to the most extensive and inclusive procedure.
18. **Myofunctional Therapy.**

19. **No-Fault State:** Benefits are not payable under this Plan for any injury received in an Accident involving a car or other motor vehicle for participants who are residents of a no-fault state and eligible for benefits under the no-fault motor vehicle law, until such time as the benefits under No-fault have been exhausted.
20. **Not Medically Necessary:** Services, supplies, treatment, facilities or equipment which the Plan determines are not Medically Necessary.
21. **Orthodontic service** unless provided elsewhere in this document.
22. **Orthognathic** surgery unless provided elsewhere in this document.
23. **Preventive Control Programs** including oral hygiene instruction; plaque control; dietary planning; lab tests; anaerobic culture, except in connection with periodontal disease; sensitivity testing; and bite registrations.
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. **Services at no 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, 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.
28. **Services Provided by a Close Relative.** See Glossary of Terms for the definition of Close Relative.
29. 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.
30. **Splints** unless necessary as the result of an Accidental Injury.
31. **Supplies** for plaque control or oral hygiene that can be purchased over-the-counter.
32. **Telemedicine.**
33. **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. **This does not apply to Orthodontic Services.**
34. **Treatment of disturbances** of the temporomandibular joint, craniomandibular disfunctions, myofacial pain syndrome, or any other disorder of the joint linking the jaw to the skull and the associated muscles. This exclusion does not pertain to temporomandibular joint radiographs.
35. **Usual and Customary Charges:** Charges or the portion thereof which are in excess of the Usual and Customary charge, fee schedule or the negotiated fee.
36. **Dental Care which is not customarily performed.**
37. **Dental care received during a stay in a hospital owned or operated by a federal, state, province or political unit unless required by statute or regulations.**
38. **Services performed by a Close Relative or by someone who ordinarily lives in the Covered Person's home.**
39. **Any treatment which is court ordered, ordered as a condition of parole, probation, or custody or visitation evaluation.**

40. Any service deemed to have a Poor Prognosis.

41. General anesthesia and intravenous sedation, unless Medically Necessary.

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

CLAIMS AND APPEAL PROCEDURES

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.

PERSONAL REPRESENTATIVE

Personal 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. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

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

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will 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 15 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.

Fee Schedule: 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.

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.

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 90th 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

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.

Determination Period On Hold: The time period that the Plan has to decide a claim may be put on hold ("tolled") when additional information is necessary from the Covered Person to process the claim. When claims information is missing, a notice requesting the necessary information will be sent to the Covered Person. The Covered Person then has 45 calendar days within which to provide the missing information.

If the Covered Person does not provide needed information to the Plan within 45 calendar days of the date on the notice, the Plan will make a decision on the claim based upon the information it has at that time, which may result in a denial or partial denial. The Covered Person will be fully responsible for payment of expenses not covered because of a denied or partially denied claim.

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 Personal 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 a Personal Representative.

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

- The Covered Person must file the appeal within 180 days of the date he or she received the EOB form from the Plan showing that the claim was denied. The Plan will assume that the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- Covered Persons or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Covered Persons may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based in whole or in part on a dental judgment, the Plan will consult with a dental care professional with training and experience in the relevant dental field. This dental care professional may not have been involved in the original denial decision, nor be supervised by the dental care professional who was involved. If the Plan has obtained dental or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.

- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process, in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to You. The notification will provide the Covered Person with the information outlined under the “Adverse Benefit Determination” section above. It will also notify You of Your right to file suit under ERISA after You have completed all mandatory appeal levels described in this SPD.

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

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

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

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

UMR
CLAIMS APPEAL UNIT
PO BOX 8086
WAUSAU WI 54402-8086

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. If such evidence is received at a point in the process where we are unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

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

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

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

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.
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

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

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

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

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT

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 the employer's Human Resource policy on family and medical leaves of absence, as if the employee was actively at work if the following conditions are met:

- (A) Contribution is paid; and
- (B) The employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

- (A) The leave period required by the Federal Family and Medical Leave Act of 1993 and any amendment; or
- (B) The leave period required by applicable state law.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent child will become covered as of the date specified in a judgement, 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:

- (A) The name and last known mailing address of the participant; and
- (B) The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient); and
- (C) 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
- (D) The period to which the order applies.

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

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

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

HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION

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 Your PHI.

This Plan agrees that it will only Disclose Your 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 Your 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 Your PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations. Additionally, this Plan will Use and Disclose Your PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share Your PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of Your PHI.

This Plan shall Disclose Your 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 Your 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 Your PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms of this section has 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 Your PHI:

- The Plan Sponsor will only Use and Disclose Your PHI (including Electronic PHI) for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. Your 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 Your PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to Your PHI;
- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI to agree to implement reasonable and appropriate security measures to protect Electronic PHI;
- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;
- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;
- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;
- The Plan Sponsor and the Plan will not use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;
- The Plan Sponsor will allow You or this Plan to inspect and copy any PHI about You 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 You 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 Your 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. You 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 Your 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 Your PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs Your 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 Your 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 Your PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to Your PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Human Resources, Accounting, Legal and the Treasurer/Senior Financial Executive.

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

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.

Disclose or 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, 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 Plan participants within 60 days following the adopted formal action that makes material changes to the Plan.

Your Rights if Plan is Amended or Terminated

If this Plan is amended, Your rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not You have 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 You receive notice of termination.

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

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

Distribution Of Assets Upon Termination Of Plan

Plan assets will be held for the exclusive purpose of providing benefits and defraying reasonable expenses, and will not inure to the benefit of the employer, except:

- If Plan assets consist of both participant contributions and employer contributions, the employer will determine which portion of the remaining assets is from the employer contributions and which portion is from participant contributions. The assets that are from participant contributions will be used to cover the cost of incurred Covered Expenses and reasonable expenses to administer the Plan. The portion of assets that are from employer contributions can be reverted to the employer.
- If all Plan assets are from employer contributions, the assets at the time of termination can revert to the employer, once incurred Plan expenses have been paid.

No Contract of Employment

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

GLOSSARY OF TERMS

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

Actively At Work means actively working at Your regular duties full time for a minimum of 35 hours and part time for a minimum of 25 hours, at Your employer's regular place of business or at some other place to which Your employer's business requires You to travel. You will be considered at work on a day that is not a scheduled work day if You were at work on the last scheduled work day.

Close Relative means a member of You or Your spouse's, Your Domestic Partners immediate family. Immediate family includes mother, father, grandmother, grandfather, step parents, step grandparents, siblings, step siblings, half siblings, children, and step children.

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 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 document

Domestic Partner means: An unmarried person with whom the covered employee shares a committed relationship, is jointly responsible for the other's welfare and financial obligations, is at least 18 years of age, is not related by blood, maintains the same residence and is not married or legally separated from anyone else. A Domestic Partner certification maybe required to be completed and filed with the Plan at the time enrollment of the Domestic Partner is requested.

For Your Domestic Partner to qualify as a Dependent, You and Your partner must complete an affidavit declaring that You and Your partner:

- Are in a relationship of mutual support, caring and commitment and are responsible for each other's welfare.
- Have maintained this relationship for the past six months and intend to do so indefinitely.
- Have shared a primary residence for the past six months and intend to do so indefinitely.
- Are not married to anyone else and do not have other Domestic Partners;
- Are financially interdependent.

Effective Date means the first day of coverage as defined in this document.

Essential Health Benefits (as related to Dental Expenses) means routine oral exams, routine X-rays, routine cleanings, and sealants applied to specific molars as defined under the Patient Protection and Affordable Care Act.

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

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

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered Experimental, Investigational or Unproven. 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.

Family Deductible means the amount of Individual Deductibles payable by a family in a calendar year. Refer to the Out-of-Pocket Expenses Provision.

Individual Deductible means the amount of Covered Expenses that You are responsible to pay each calendar year before the Plan pays any benefits. Refer to the Out-of-Pocket Expenses Provision.

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

Legal Guardianship/Guardian means the individual 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 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, medicines, or facilities necessary and appropriate for the diagnosis, care, or treatment of an Illness or Injury and which meets all of the following criteria as determined by the Plan's Medical Director or designee:

- In accordance with *Generally Accepted Standards of Dental Practice*; and
- 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.

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, medicine, equipment or facility Medically Necessary.

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

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 ROYAL NEIGHBORS OF AMERICA Group Benefit Plan.

Third Party Administrator (TPA) is a service provider hired by the Plan to process dental claims or 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 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.