

THE CLARK STATE
COMMUNITY COLLEGE
DENTAL BENEFIT PLAN
PLAN DOCUMENT

Effective Date: March 1, 2003

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SCHEDULE OF BENEFITS

The following *Schedule of Benefits* is designed as a quick reference. For complete provisions of the *Plan's* benefits, refer to the following sections: *Dental Claim Filing Procedure, Dental Expense Benefit and Plan Exclusions.*

<i>DENTAL BENEFITS :</i>

Calendar Year Deductible:	
Individual	\$25
Family (Aggregate)	\$50
The deductible is waived for diagnostic & preventive dental services and for orthodontic services.	
Maximum Benefit Per Covered Person:	
Preventive, Basic and Major Dental services per calendar year (other than Orthodontics)	\$1,250
Orthodontic services while covered by this <i>Plan</i> (includes adult orthodontia)	\$1,500
Percentage of Customary and Reasonable Amount Payable For:	
Diagnostic & Preventive Dental Services	100%
Basic Dental Services	80%
Major Dental Services	60%
Orthodontic Services	60%

DENTAL EXPENSE BENEFIT

Subject to all the terms of the *Plan*, the *Plan* will pay a dental benefit for covered dental expenses. The dental benefit is a percentage of the *customary and reasonable amount* for covered dental expenses, as shown on the *Schedule of Benefits*.

DEDUCTIBLE

Individual Deductible

The individual deductible is the dollar amount of *covered expense* which each *covered person* must incur during each calendar year before the *Plan* pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits*.

Family Deductible

If, in any calendar year, covered members of a family incur *covered expenses* that are subject to the deductible that are equal to or greater than the dollar amount of the family deductible shown on the *Schedule of Benefits*, then the family deductible will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

Deductible Carry-Over

Amounts *incurred* during October, November and December and applied toward the individual deductible of any *covered person*, will also be applied to the individual deductible of that *covered person* in the next calendar year.

COINSURANCE

The *Plan* pays a specified percentage of the *customary and reasonable amount* for *covered expenses*. That percentage is listed on the *Schedule of Benefits*. The *covered person* is responsible for the difference.

MAXIMUM BENEFIT

The maximum calendar year benefit payable on behalf of a *covered person* for covered dental expense is stated on the *Schedule of Benefits*. If the *covered person's* coverage under the *Plan* terminates and he subsequently returns to coverage under the *Plan* during the calendar year, the *maximum benefit* will be calculated on the sum of benefits paid by the *Plan*.

The *maximum benefit* for orthodontic treatment while a *covered person* is covered by this *Plan* is also shown on the *Schedule of Benefits*. If the *covered person* receives more than one course of orthodontic treatment while covered by this *Plan* and if it can be clearly shown that any later course of treatment is not a part of a previous course of treatment, then the *covered person* will be entitled to a separate *maximum benefit* for each course of treatment.

ALTERNATIVE TREATMENT

In the event the *dentist* recommends a particular course of treatment and a lower-cost alternative would be as effective, benefits shall be limited to the lower-cost alternative. Any balance remaining, as a result of the *covered person's* choice to obtain the higher-cost treatment will be the *covered person's* responsibility.

DENTAL INCURRED DATE

A dental procedure will be deemed to have commenced on the date the covered dental expense is ***incurred***, except as follows:

1. For installation of a prosthesis, other than a bridge or crown, on the date the impression was made;
2. For a crown, bridge or gold restoration, on the date the tooth or teeth are first prepared;
3. For endodontic treatment, on the date the pulp chamber is opened.

There are times when one overall charge is made for all or part of a course of treatment. In this case the ***claims processor*** will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be ***incurred*** as each visit or treatment is completed.

COVERED DENTAL EXPENSES

Subject to the limitations and exclusions, covered dental expenses shall include the necessary services, supplies, or treatment listed below and on the following pages. No dental benefit will be paid for any dental service, supply or treatment which is not on the following list of covered dental expenses.

Class I Diagnostic and Preventive Dental Services

1. Routine oral examination: Initial or periodic, limited to twice in any twelve (12) month period.
2. Prophylaxis: Scaling and cleaning of teeth, limited to twice in any twelve (12) month period.
3. Dental x-rays as follows:
 - a. Supplementary bite-wing x-rays.
 - b. Panorex or full mouth series, limited to one every thirty-six (36) months.
 - c. Other dental x-rays necessary for the diagnosis of a specific condition requiring treatment.
4. Topical application of fluoride, limited to one treatment in any twelve (12) month period.
5. Space maintainers (not made of precious metals), designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth) including all adjustments within six (6) months of installation. This does not include space maintainers used in orthodontics to create a space between teeth.
6. Topical application of sealant to permanent posterior teeth, for ***dependent*** children through the age of thirteen (13).
7. ***Emergency*** palliative treatment primarily for relief of dental pain, not cure. Only paid as a separate benefit when no other treatment (except x-rays) is rendered during the visit.

Class II Basic Dental Services

1. Sedative fillings covered as a separate procedure only if no other service (except x-rays) is rendered during the visit.
2. Restorations (fillings) to restore teeth to normal function, using amalgam, silicate, acrylic, synthetic, and composite filling materials to restore teeth broken down by decay or *injury*.
3. Pin retention when part of the restoration instead of gold or crown retention.
4. Periodontics as follows:
 - a. Gingivectomy/gingivoplasty, gingival curettage, gingival flap procedure or mucogingival surgery.
 - b. Scaling and root planing.
 - c. Pedicle and free soft tissue grafts, and vestibuloplasty.
 - d. Occlusal adjustment.
 - e. Excision of pericoronal gingiva.
 - f. Periodontal prophylaxis.
 - g. Osseous surgery.
5. Endodontics as follows:
 - a. Direct Pulp Capping.
 - b. Pulpotomy.
 - c. Root canal therapy.
 - d. Apicoectomy.
 - e. Hemisection.
 - f. Retrograde fillings.
6. Oral surgery, including customary postoperative treatment furnished in connection with oral surgery, as follows:
 - a. Simple extraction of one or more teeth.
 - b. Surgical extraction of erupted teeth and of soft tissue, partially bony, and completely bony impacted teeth.
 - c. Extraction of tooth root.
 - d. Incision and drainage of a tumor or a cyst.
 - e. Alveolectomy, alveoloplasty, and frenectomy.
 - f. Exostosis or hyperplastic tissue and excision of oral tissue for biopsy.
 - g. Re-implantation or transplantation of a natural tooth.
 - h. General anesthesia, only when provided in conjunction with a surgical procedure.
7. Therapeutic injections of antibiotics administered by a *dentist*.
8. Repairs and adjustments to full or partial dentures.
9. Relining of present dentures, but only if they were installed more than six (6) months earlier.
10. Rebased of present dentures, but only if they were installed more than six (6) months earlier.
11. Denture adjustment, only if done more than six (6) months after the initial insertion of the denture.
12. Repair or recementing of crowns, inlays, onlays or bridgework.

Class III Major Dental Services

1. Post and core on permanent teeth only.
2. Plastic or stainless steel crowns will be covered for primary teeth only.
3. Gold Inlays and Onlays: Covered only when the tooth cannot be restored by basic restorations. Restorations on teeth which are anterior to the first bicuspid are not covered.
4. Porcelain Restorations: Covered only when the tooth cannot be restored by basic restorations. Restorations on teeth which are posterior to the first bicuspid are not covered.
5. Crowns: Covered only when the tooth cannot be restored by basic restorations.
6. Initial installation of fixed bridge (including abutments) to replace one (1) or more natural teeth extracted.
7. Removable bridge, partial or complete dentures to replace one (1) or more natural teeth extracted.
8. Replacement of an existing partial or full removable denture or fixed bridge, or the addition of teeth to existing bridgework to replace extracted natural teeth. However, only replacement or additions that meet the “*Prosthesis Replacement Rule*” below will be covered.
9. Complete dentures for teeth extracted.

Prosthesis Replacement Rule

The Prosthesis Replacement Rule requires that replacements for or additions to existing dentures, crowns or bridgework will be covered only if satisfactory evidence is furnished that one of the following services applies:

1. The replacement or addition of teeth is required to replace one (1) or more teeth extracted after the existing denture or bridgework was installed.
2. The existing denture or bridge cannot be made serviceable.

Covered expenses for both a temporary and permanent prosthesis will be limited to the charge for the permanent prosthesis.

Class IV Orthodontic Services

1. Any dental expense furnished in connection with the orthodontic treatment.
2. Surgical exposure of impacted or unerupted teeth in connection with orthodontic treatment. Includes routine x-rays, local anesthetics, and post-surgical care.
3. Active appliances. Includes diagnostic services, the treatment plan, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.
4. Comprehensive full-banded and bracketed orthodontic treatment.
5. Fixed or cemented appliance to control harmful habits.

DENTAL EXCLUSIONS

In addition to the *Plan Exclusions*, no benefit will be provided under this *Plan* for dental expenses *incurred* by a *covered person* for the following:

1. Charges for any device ordered while the individual was covered under this *Plan* and not delivered or installed until after termination of coverage, except:
 - a. For fixed bridgework and full or partial dentures, the first impressions were taken and/or abutment teeth fully prepared while the individual was covered and the device installed or delivered within three (3) calendar months after termination of coverage, or
 - b. For a crown, inlay or onlay, the tooth was prepared while the individual was covered and the crown, inlay or onlay installed within three (3) calendar months after termination of coverage, or
 - c. For root canal therapy, the pulp chamber of the tooth was opened while the individual was covered and the treatment completed within three (3) calendar months after termination of coverage.
2. Replacement of duplicate, lost, missing or stolen appliances or prosthetic devices.
3. Charges for all services, supplies and treatment related to dental implants.
4. Any procedure not listed under *Covered Dental Expense*.
5. Any procedure which began before the date the *covered person's* dental coverage started, to include a service which is:
 - a. An appliance, or modification of an appliance, for which an impression was made before such person became covered, or
 - b. A crown, bridge or gold restoration, for which a tooth was prepared before such person became covered, or
 - c. Root canal therapy, for which the pulp chamber was opened before such person became covered.

X-rays and prophylaxis shall not be deemed to start a dental procedure.
6. Services, supplies or treatment that are cosmetic in nature, including charges for personalization or characterization of dentures. Veneers or coverings placed on teeth except when used to return the tooth to normal form and function are considered cosmetic in nature.
7. Surgical services with respect to congenital or developmental malformations. These conditions include: cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis, and anodontia.
8. Appliances, restoration or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, except as provided under *Orthodontic Services*.
9. Charges for services, supplies or treatment for which benefits are payable under any employer sponsored group medical or dental plan.

10. A service not furnished by a *dentist*, except:
 - a. Services performed by a licensed dental hygienist under a *dentist's* supervision;
 - b. X-rays ordered by a *dentist*; and
 - c. Denturist.
11. Charges for over-dentures, including related root canal therapy and supportive restorations.
12. Replacement of a prosthetic which in the *dentist's* opinion can be repaired or does not need replacement.
13. A posterior fixed prosthetic appliance when done in connection with a removable appliance in the same arch.
14. Charges in excess of the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.
15. Charges resulting from changing from one dentist to another while receiving treatment, or resulting from receiving care from more than one dentist for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one dentist had performed all the required dental services.
16. Charges for precision attachments, semi -precision attachments, instruction in dental plaque control, dental hygienics, or nutritional counseling.
17. Charges for adjustments of new dentures within six (6) months of installation.
18. Charges for failure to keep a scheduled visit with a *dentist*.

PLAN EXCLUSIONS

The **Plan** will not provide benefits for any of the items listed in this section, regardless of **medical necessity** or recommendation of a **dentist** or **professional provider**.

1. Charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.
2. Charges for an **injury** sustained or **illness** contracted while on active duty in military service, unless payment is legally required.
3. Charges for services, treatment or supplies for treatment of **illness** or **injury** which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.
4. Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Worker's Compensation law, Employer's liability law, or occupational disease law, even though the **covered person** fails to claim rights to such benefits or fails to enroll or purchase such coverage.
5. Charges in connection with any **illness** or **injury** arising out of or in the course of any employment intended for wage or profit, including self-employment.
6. Charges made for services, supplies and treatment which are not **medically necessary** for the treatment of **illness** or **injury**, or which are not recommended and approved by the attending **dentist**, except as specifically stated herein, or to the extent that the charges exceed the **customary and reasonable amount**.
7. Charges in connection with any **illness** or **injury** of the **covered person** resulting from or occurring during commission or attempted commission of a criminal battery or felony by the **covered person**.
8. To the extent that payment under this **Plan** is prohibited by any law of any jurisdiction in which the **covered person** resides at the time the expense is **incurred**.
9. Charges for services rendered and/or supplies received prior to the **effective date** or after the termination date of a person's coverage, except as specifically provided herein.
10. Any services, supplies or treatment for which the **covered person** is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.
11. Charges for services, supplies or treatment that are considered **experimental/investigational**.
12. Charges **incurred** outside the United States if the **covered person** traveled to such a location for the sole purpose of obtaining services, supplies or treatment.
13. Charges for services, supplies or treatment rendered by any individual who is a **close relative** of the **covered person** or who resides in the same household as the **covered person**.

14. Charges for services, supplies or treatment rendered by a *dentist* beyond the scope of their license; for any treatment or service which is not recommended by or performed by an appropriate *dentist*.
15. Charges for *illnesses* or *injuries* suffered by a *covered person* due to the action or inaction of any party if the *covered person* fails to provide information as specified in *Subrogation*.
16. Claims not submitted within the *Plan's* filing limit deadlines as specified in the *Dental Claim Filing Procedure* section of this document.
17. Charges for telephone consultations, completion of claim forms, charges associated with missed appointments.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

This section identifies the *Plan's* requirements for a person to participate in the *Plan*.

EMPLOYEE ELIGIBILITY

All *full-time employees* regularly scheduled to work at least 960 hours per year shall be eligible to enroll for coverage under this *Plan*. This does not include temporary or seasonal *employees*.

EMPLOYEE ENROLLMENT

An *employee* must file a written application with the *employer* for coverage hereunder for himself within thirty (30) days of becoming eligible for coverage. The *employee* shall have the responsibility of timely forwarding to the *employer* all applications for enrollment hereunder.

EMPLOYEE(S) EFFECTIVE DATE

Eligible *employees*, as described in *Employee Eligibility*, are covered under the *Plan* on the first day of *active service*.

DEPENDENT(S) ELIGIBILITY

The following describes *dependent* eligibility requirements. The *employer* will require proof of *dependent* status.

1. The term "spouse" means the spouse of the *employee* under a legally valid existing marriage between person's of the opposite sex, unless court ordered separation exists.
2. The term "child" means the *employee's* natural child, stepchild, legally adopted child, and a child for whom the *employee* or covered spouse has been appointed legal guardian, provided:
 - a. The child is less than twenty-three (23) years of age, and;
 - b. The child is unmarried, and;
 - c. The child is not regularly employed by one or more employers on a full-time basis, exclusive of scheduled vacation periods.
3. An eligible child shall also include any other child of an *employee* or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this *Plan*, even if the child is not residing in the *employee's* household. Such child shall be referred to as an *alternate recipient*. *Alternate recipients* are eligible for coverage regardless of whether the *employee* elects coverage for himself. An application for enrollment must be submitted to the *employer* for coverage under this *Plan*. The *employer/plan administrator* shall establish written procedures for determining whether a medical child support order is a QMCSO and for administering the provision of benefits under the *Plan* pursuant to a valid QMCSO. The *employer/plan administrator* reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.

4. Adopted children, who are less than 18 years of age at the time of adoption, shall be considered eligible from the date the child is *placed for adoption*.
5. Upon written notice to the *employer*, a child who has reached his or her twenty-third (23rd) birthday and is principally dependent upon the *employee* for support and maintenance, may also be included herein as an eligible *dependent* until the child's twenty-fifth (25th) birthday, provided such child is unmarried, and is a *full-time student* in a secondary school, accredited college, university or institution of higher learning and is not regularly employed by one or more employers on a full-time basis, exclusive of scheduled vacation periods. It is the *employee's* responsibility to provide the *claims processor* with proof of *full-time student status* for each semester. The *employee* must notify the *employer* when the *dependent* is no longer a *full-time student*.
6. A child who is unmarried, incapable of self-sustaining employment, and dependent upon the *employee* for support due to a mental and/or physical disability, and who was covered under the *Plan* prior to reaching the maximum age limit or due to other loss of *dependent's* eligibility and who lives with the *employee*, will remain eligible for coverage under this *Plan* beyond the date coverage would otherwise be lost.

Proof of incapacitation must be provided within thirty-one (31) days of the child's loss of eligibility and thereafter as requested by the *employer* or *claims processor*, but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

- a. Cessation of the mental and/or physical disability;
- b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Every eligible *employee* may enroll eligible *dependents*. However, if both the husband and wife are *employees*, they may choose to have one covered as the *employee*, and the spouse covered as the *dependent* of the *employee*, or they may choose to have both covered as *employees*. Eligible children may be enrolled as *dependents* of one spouse, but not both.

DEPENDENT ENROLLMENT

An *employee* must file a written application with the *employer* for coverage hereunder for his eligible *dependents* within thirty (30) days of becoming eligible for coverage; and within thirty (30) days of marriage or the acquiring of children or birth of a child. The *employee* shall have the responsibility of timely forwarding to the *employer* all applications for enrollment hereunder.

DEPENDENT(S) EFFECTIVE DATE

Eligible *dependent(s)*, as described in *Eligibility*, will become covered under the *Plan* on the later of the dates listed below, provided the *employee* has enrolled them in the *Plan* within thirty (30) days of meeting the *Plan's* eligibility requirements.

1. The date the *employee's* coverage becomes effective.
2. The date the dependent is acquired, provided any required contributions are made and the employee has applied for dependent coverage within thirty (30) days of the date acquired.
3. Newborn children shall be covered from birth, regardless of confinement, provided the *employee* has applied for *dependent* coverage within thirty (30) days of birth.
4. Coverage for a newly or to be adopted child shall be effective on the date the child is *placed for adoption*.

SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)

An ***employee*** or ***dependent*** who did not enroll for coverage under this ***Plan*** because he was covered under other group coverage or had dental insurance coverage at the time he was initially eligible for coverage under this ***Plan***, may request a special enrollment period if he is no longer eligible for the other coverage. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Termination of the other coverage (including exhaustion of COBRA benefits)
2. Cessation of employer contributions toward the other coverage
3. Legal separation or divorce
4. Termination of other employment or reduction in number of hours of other employment
5. Death of ***dependent*** or spouse.

The end of any extended benefits period, which has been provided due to any of the above, will also be considered a loss of eligibility.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage).

The ***employee*** or ***dependent*** must request the special enrollment and enroll no later than thirty (30) days from the date of loss of other coverage.

SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)

An ***employee*** who is not covered under the ***Plan***, but who acquires a new ***dependent*** may request a special enrollment period. For the purposes of this provision, the acquisition of a new ***dependent*** includes:

- marriage
- birth of a ***dependent*** child
- adoption or placement for adoption of a ***dependent*** child

The ***employee*** must request the special enrollment within thirty (30) days of the acquisition of the ***dependent***.

The ***effective date*** of coverage as the result of a special enrollment shall be:

1. in the case of marriage, the date of such marriage;
2. in the case of a ***dependent's*** birth, the date of such birth;
3. in the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

OPEN ENROLLMENT

Open enrollment is the period designated by the *employer* during which the *employee* may change benefit plans or enroll in the *Plan* if he did not do so when first eligible or does not qualify for a special enrollment period. An open enrollment will be permitted once in each calendar year between July 1st and August 31st.

During this open enrollment period, an *employee* and his *dependents* who are covered under this *Plan* or covered under any *employer* sponsored dental plan may elect coverage or change coverage under this *Plan* for himself and his eligible *dependents*. An *employee* must make written application as provided by the *employer* during the open enrollment period to change benefit plans.

The *effective date* of coverage as the result of an open enrollment period will be the following September 1st.

Except for a status change listed below, the open enrollment period is the only time an *employee* may change benefit options or modify enrollment. Status changes include:

1. Change in family status. A change in family status shall include only:
 - a. Change in *employee's* legal marital status;
 - b. Change in number of *dependents*;
 - c. Termination or commencement of employment by the *employee*, spouse or *dependent*;
 - d. Change in work schedule;
 - e. *Dependent* satisfies (or ceases to satisfy) *dependent* eligibility requirements;
 - f. Change in residence or worksite of *employee*, spouse or *dependent*.
2. Change in the cost of coverage under the *employer's* group medical plan.
3. Cessation of required contributions.
4. Taking or returning from a *leave of absence* under the Family and Medical Leave Act.
5. Significant change in the health coverage of the *employee* or spouse attributable to the spouse's employment.
6. A Special Enrollment Period as mandated by the Health Insurance Portability and Accountability Act.
7. A court order, judgment or decree.
8. Entitlement to Medicare or Medicaid.
9. A COBRA qualifying event.

TERMINATION OF COVERAGE

Except as provided in the *Plan's Continuation of Coverage* (COBRA) or *Family Security Benefits* provision, coverage will terminate on the earliest of the following dates:

TERMINATION OF EMPLOYEE COVERAGE

1. The date the *employer* terminates the *Plan* and offers no other group dental plan.
2. The date the *employee* ceases to meet the eligibility requirements of the *Plan*.
3. The date employment terminates, as defined by the *employer's* personnel policies.
4. The date the *employee* becomes a full-time, active member of the armed forces of any country.
5. The date the *employee* ceases to make any required contributions.

TERMINATION OF DEPENDENT(S) COVERAGE

1. The date the *employer* terminates the *Plan* and offers no other group dental plan.
2. The date the *employee's* coverage terminates. However, if the *employee* remains eligible for the *Plan*, but elects to discontinue coverage, coverage may be extended for *alternate recipients*.
3. The date such person ceases to meet the eligibility requirements of the *Plan*.
4. The date the *employee* ceases to make any required contributions on the *dependent's* behalf.
5. Cessation of *full-time student status* for *dependent* children age twenty-three (23) or older shall terminate coverage on the earliest of the following dates:
 - a. The date the *dependent* is no longer a *full-time student*.
 - b. The date the school reconvenes after school vacation, if the *dependent* fails to meet the *full-time student* criteria.
 - c. The date graduation occurs.
 - d. The date the *dependent* reaches the *full-time student status* age as stated in *Eligibility*.
6. The date the *dependent* becomes a full-time, active member of the armed forces of any country.
7. The date the *Plan* discontinues *dependent* coverage for any and all *dependents*.

FAMILY SECURITY BENEFITS

In the event of an *employee's* death, dental benefits will be continued for the employee's *dependents* who were covered on the date of death of the deceased employee, without payment of premiums, until the earliest of the following dates:

1. The date of remarriage of the deceased employee's spouse, in which case the coverage for all covered *dependents* terminates; or
2. The date a dependent ceases to qualify as a covered *dependent* for any reason other than lack of primary support by the deceased employee; or
3. Two years from the date of death of the deceased employee; or
4. The date the *employer* terminates the *Plan* and offers no other group dental plan.

The coverage which is continued for covered *dependents* will be the coverage in force at the time of the deceased employee's death.

The coverage which is continued for covered *dependent* children because of the deceased employee's death will not be affected if the surviving spouse dies during the two (2) year (maximum) continuation of coverage.

Any extension of benefits after termination of coverage applies to covered *dependents* when the coverage provided by this *Family Security Benefit* terminates.

LEAVE OF ABSENCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for *employees* and/or *dependents*, when the *employee* is on an authorized *leave of absence* from the *employer*.

LAYOFF

Coverage may be continued for a limited time, contingent upon payment of any required contributions for *employees* and/or *dependents*, when the *employee* is subject to an *employer layoff*.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

An *employee* who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this *Plan* for up to twelve (12) weeks during any twelve (12) month period.

Contributions

During this leave, the *employer* will continue to pay the same portion of the *employee's* contribution for the *Plan*. The *employee* shall be responsible to continue payment for eligible *dependent's* coverage and any remaining *employee* contributions. If the covered *employee* fails to make the required contribution during a FMLA leave within thirty (30) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

Reinstatement

If coverage under the **Plan** was terminated during an approved FMLA leave, and the **employee** returns to **active work** immediately upon completion of that leave, **Plan** coverage will be reinstated on the date the **employee** returns to **active work** as if coverage had not terminated, provided the **employee** makes any necessary contributions and enrolls for coverage within thirty (30) days of his return to **active work**.

Repayment Requirement

The **employer** may require **employees** who fail to return from a leave under FMLA to repay any contributions paid by the **employer** on the **employee's** behalf during an unpaid leave. This repayment will be required only if the **employee's** failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or events beyond the **employee's** control.

EMPLOYEE REINSTATEMENT

An **employee** who returns to work after a separation of service will be considered a new **employee** for purposes of eligibility and will be subject to all eligibility requirements, including all requirements relating to the **effective date** of coverage.

CERTIFICATES OF COVERAGE

The **plan administrator** shall provide each terminating **covered person** with a Certificate of Coverage, certifying the period of time the individual was covered under this **Plan**. For **employees** with **dependent** coverage, the certificate provided may include information on all covered **dependents**. This **Plan** intends to, at all times, comply with the provisions of the Health Insurance Portability and Accountability Act of 1996.

CONTINUATION OF COVERAGE

In order to comply with federal regulations, this *Plan* includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Public Health Services Act. This continuation of coverage may be commonly referred to as "COBRA coverage."

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes dental benefits as provided under the *Plan*.

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a *covered person* to lose coverage under this *Plan* or cause an increase in required contribution, even if such loss of coverage or increase in required contributions does not take effect immediately, and allow such person to continue coverage beyond the date described in *Termination of Coverage*:

1. Death of the *employee*.
2. The *employee's* termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the *Plan*.
3. Divorce or legal separation from the *employee*.
4. The *employee's* entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this *Plan*.
5. A *dependent* child no longer meets the eligibility requirements of the *Plan*.
6. The last day of leave under the Family and Medical Leave Act of 1993, or an earlier date on which the *employee* informs the *employer* that he or she will not be returning to work.
7. The call-up of an *employee* reservist to active duty.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered *employee*, or a child's loss of *dependent* status, the *employee* or *dependent* must notify the *employer* of that event within sixty (60) days of the event. Failure to provide such notice to the *employer* will result in the person forfeiting their rights to continuation of coverage under this provision.
2. The *employee* or *dependent* will be notified of his rights to continuation of coverage, and what process is required to elect continuation of coverage.
3. After receiving notice, the *employee* or *dependent* has sixty (60) days to decide whether to elect continued coverage. Each person who was covered under the *Plan* on the day before the qualifying event, has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the *employee* or *dependent* chooses to have continued coverage, he must advise the *employer* in writing of this choice. The *employer* must receive the written election no later than the last day of the sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:

- a. The date coverage under the *Plan* would otherwise end; or
 - b. The date the person receives the notice from the *employer* of his or her rights to elect continuation of coverage.
4. Within forty-five (45) days after the date the person notifies the *employer* that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are to be made monthly, and are due in advance, on the first day each month.

COST OF COVERAGE

1. The *employer* requires that *covered persons* pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. Except for the initial payment (see above), payments must be remitted to the *employer* or the *employer's* designated representative, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.

WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the initial payment is made within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for *dependents* acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the *Plan*.

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse or *dependent* child newly acquired during continuation coverage is eligible to be enrolled as a *dependent*. The standard enrollment provision of the *Plan* applies to enrollees during continuation coverage. A *dependent* acquired and enrolled after the original qualifying event, other than a child born to or *placed for adoption* with a covered *employee* during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

SUBSEQUENT QUALIFYING EVENTS

Once covered under continuation coverage, it is possible for a second qualifying event to occur, including:

1. Death of an *employee*.
2. Divorce or legal separation from an *employee*.
3. *Employee's* entitlement to Medicare.
4. The child's loss of *dependent* status.

If one of these subsequent qualifying events occurs during the period of continuation coverage, a *dependent* may be entitled to a second continuation period. This period will in no event continue beyond thirty-six (36) months from the date of the first qualifying event.

Only a person covered prior to the original qualifying event or a child born to or *placed for adoption* with a covered *employee* during a period of COBRA continuation is eligible to continue coverage again as the result of a subsequent qualifying event. Any other *dependent* acquired during continuation coverage is not eligible to continue coverage as the result of a subsequent qualifying event.

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months (or twenty-nine (29) months – see paragraph 6 below) from the date continuation began because of a reduction of hours or termination of employment of the *employee*, or because of the call-up to military duty or the last day of leave under the Family and Medical Leave Act of 1993.
2. Thirty-six (36) months from the date continuation began for *dependents* whose coverage ended because of the death of the *employee*, divorce or legal separation from the *employee*, or the child's loss of *dependent* status.
3. The end of the period for which contributions are paid if the *covered person* fails to make a payment by the date specified by the *employer*.
4. The date coverage under this *Plan* ends and the *employer* offers no other group dental benefit plan.
5. The date the *covered person* first becomes entitled to Medicare after the date of the *covered person's* original election of continuation coverage.
6. A person who loses coverage on account of a qualifying event which is termination of employment or reduction of hours of employment and who is *totally disabled*, or who is entitled to continuation coverage on account of the same employment-related qualifying event as the disabled person, may extend the period of continuation coverage from eighteen (18) months to twenty-nine (29) months. The person must be disabled for Social Security purposes at the time of the qualifying event or within sixty (60) days thereafter. The disabled person (or another individual) must submit proof of the Social Security Administration's disability determination to the *employer* within the initial eighteen (18) month period of continuation coverage and no later than sixty (60) days after the Social Security Administration's determination. Should the disabled person fail to notify the *plan administrator* of the Social Security Administration's determination within sixty (60) days of the determination, the disabled person (and others entitled to disability extension on account of that person) will then be entitled to whatever period of continuation he or they would otherwise be entitled to, if any. The *employer* may charge one hundred and fifty percent (150%) of the contribution during the additional eleven (11) months of continuation coverage. If a final determination is made that the individual is no longer disabled, the individual must provide notice of that determination within thirty (30) days of that finding.
7. For the spouse or *dependent* child of a covered *employee* who becomes entitled to Medicare prior to the spouse or *dependent's* election for continuation coverage, thirty-six (36) months from the date the covered *employee* becomes entitled to Medicare.

MILITARY MOBILIZATION

If an *employee* or an *employee's dependent* is called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), the *employee* or the *employee's dependent* may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the *employee* or *employee's dependent* may not be required to pay more than the *employee's* share, if any, applicable to that coverage. If the leave is thirty-one (31) days or longer, then the *employer* may require the *employee* or *employee's dependent* to pay no more than 102% of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Eighteen (18) months beginning on the day that the leave commences, or
2. A period beginning on the day that the leave began and ending on the day after the *employee* fails to return to employment within the time allowed.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA. Upon return from active duty, the *employee* or the *employee's dependent* coverage will be reinstated without a waiting period.

DENTAL CLAIM FILING PROCEDURE

Claims for *Plan* benefits are “post-service claims” and are subject to the rules described in *Post-Service Claim Procedure*.

POST-SERVICE CLAIM PROCEDURE

FILING A CLAIM

1. A claim form is to be completed for each covered family member at the beginning of the calendar year and for each claim involving an *injury*. Appropriate claim forms are available from the Human Resource Department.
2. Claims should be submitted to the *claims processor* at the address noted below:

CoreSource, Inc.
P.O. Box 6118
Westerville, Ohio 43086-6118

The date of receipt will be the date the claim is received by the *claims processor*.

3. All claims submitted for benefits must contain all of the following:
 - a. Name of patient.
 - b. Patient’s date of birth.
 - c. Name of *employee*.
 - d. Address of *employee*.
 - e. Name of *employer* and group number.
 - f. Name, address and tax identification number of provider.
 - g. *Employee* Social Security Number.
 - h. Date of service.
 - i. Description of service and procedure number.
 - j. Charge for service.
 - k. The nature of the *accident, injury* or *illness* being treated.

Cash register receipts, credit card copies and cancelled checks are not acceptable.

4. Properly completed claims not submitted within fifteen (15) months from the date the services were rendered will not be a *covered expense* and will be denied.

The *covered person* may ask the dental care provider to submit the claim directly to the *claims processor* as outlined above, or the *covered person* may submit the bill with a claim form. However, it is ultimately the *covered person’s* responsibility to make sure the claim for benefits has been filed.

NOTICE OF AUTHORIZED REPRESENTATIVE

The *covered person* may provide the *plan administrator* or their designee with a written authorization for an authorized representative to represent and act on behalf of a *covered person* and consent to the release of information related to the *covered person* to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department.

NOTICE OF CLAIM

A claim for benefits should be submitted to the *claims processor* within ninety (90) calendar days after the occurrence or commencement of any services by the *Plan*, or as soon thereafter as reasonably possible.

Failure to file a claim within the time provided shall not invalidate or reduce a claim for benefits if: (1) it was not reasonably possible to file a claim within that time; and (2) that such claim was furnished as soon as possible, but no later than fifteen (15) months after the loss occurs or commences, unless the claimant is legally incapacitated.

Notice given by or on behalf of a *covered person* or his beneficiary, if any, to the *plan administrator* or to any authorized agent of the *Plan*, with information sufficient to identify the *covered person*, shall be deemed notice of claim.

TIMEFRAME FOR BENEFIT DETERMINATION

After a completed claim has been submitted to the *claims processor*, and no additional information is required, the *claims processor* will generally complete its determination of the claim within thirty (30) calendar days of receipt of the completed claim unless an extension is necessary due to circumstances beyond the *Plan's* control.

After a completed claim has been submitted to the *claims processor*, and if additional information is needed for determination of the claim, the *claims processor* will provide the *covered person* (or authorized representative) with a notice detailing information needed. The notice will be provided within thirty (30) calendar days of receipt of the completed claim and will state the date as of which the *Plan* expects to make a decision. The *covered person* will have forty-five (45) calendar days to provide the information requested, and the *Plan* will complete its determination of the claim within fifteen (15) calendar days of receipt by the *claims processor* of the requested information. Failure to respond in a timely and complete manner will result in the denial of benefit payment.

NOTICE OF BENEFIT DENIAL

If the claim for benefits is denied, the *plan administrator* or their designee shall provide the *covered person* or authorized representative with a written Notice of Benefit Denial within the timeframes described immediately above.

The Notice of Benefit Denial shall include an explanation of the denial, including:

1. The specific reasons for the denial.
2. Reference to the *Plan* provisions on which the denial is based.
3. A description of any additional material or information needed and an explanation of why such material or information is necessary.
4. A description of the *Plan's* claim review procedure and applicable time limits.

5. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:
 - a. A copy of that criterion, or
 - b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
6. If denial was based on *medical necessity, experimental/investigational* treatment or similar exclusion or limit, the *Plan* will supply either:
 - a. An explanation of the scientific or clinical judgment, applying the terms of the *Plan* to the *covered person's* dental circumstances, or
 - b. A statement that such explanation will be supplied free of charge, upon request.

APPEALING A DENIED CLAIM

The “*named fiduciary*” for purposes of an appeal of a Post-Service Claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the *claims processor*.

A *covered person*, or the *covered person's* authorized representative, may request a review of a denied claim by making written request to the *named fiduciary* within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the *covered person* feels the claim should not have been denied.

The following describes the review process and rights of the *covered person*:

1. The *covered person* has a right to submit documents, information and comments.
2. The *covered person* has the right to access, free of charge, *relevant information* to the claim for benefits.
3. The review takes into account all information submitted by the *covered person*, even if it was not considered in the initial benefit determination.
4. The review by the *named fiduciary* will not afford deference to the original denial.
5. The *named fiduciary* will not be:
 - a. The individual who originally denied the claim, nor
 - b. Subordinate to the individual who originally denied the claim.
6. If original denial was, in whole or in part, based on dental judgment,
 - a. The *named fiduciary* will consult with a *professional provider* who has appropriate training and experience in the field involving the dental judgment; and
 - b. The *professional provider* utilized by the *named fiduciary* will be neither:
 - i. An individual who was consulted in connection with the original denial of the claim, nor
 - ii. A subordinate of any other *professional provider* who was consulted in connection with the original denial.
7. If requested, the *named fiduciary* will identify the dental or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION ON APPEAL

The *plan administrator* or their designee shall provide the *covered person* (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.
2. Reference to specific *Plan* provisions on which the denial is based.
3. A statement that the *covered person* has the right to access, free of charge, *relevant information* to the claim for benefits.

4. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
 - a. A copy of that criterion, or
 - b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
5. If the denial was based on *medical necessity, experimental/investigational* treatment or similar exclusion or limit, the *Plan* will supply either:
 - a. An explanation of the scientific or clinical judgment, applying the terms of the *Plan* to the claimant's dental circumstances, or
 - b. A statement that such explanation will be supplied free of charge, upon request.

FOREIGN CLAIMS

In the event a *covered person* incurs a *covered expense* in a foreign country, the *covered person* shall be responsible for providing the following information to the *claims processor* before payment of any benefits due are payable.

1. The claim form, provider invoice and any documentation required to process the claim must be submitted in the English language.
2. The charges for services must be converted into U.S. dollars.
3. A current published conversion chart, validating the conversion from the foreign country's currency into U.S. dollars, must be submitted with the claim.

COORDINATION OF BENEFITS

The *Coordination of Benefits* provision is intended to prevent duplication of benefits. It applies when the **covered person** is also covered by any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all plans will not exceed 100% of "allowable expenses." Only the amount paid by this **Plan** will be charged against the **maximum benefit**.

The *Coordination of Benefits* provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses **incurred** while covered under this **Plan**, part or all of which would be covered under this **Plan**. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this **Plan**.

When this **Plan** is secondary, "Allowable Expense" will include any deductible or **coinsurance** amounts not paid by the Other Plan(s).

When this **Plan** is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the **covered person** for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for **covered persons** in a group, whether on an insured or uninsured basis;
2. Dental service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;
5. Any coverage under a government program and any coverage required or provided by any statute;
6. Any plan or policies funded in whole or in part by an employer, or deductions made by an employer from a person's compensation or retirement benefits;
7. Labor/management trusteed, union welfare, employer organization, or employee benefit organization plans.

"This **Plan**" shall mean that portion of the **employer's Plan** which provides benefits that are subject to this provision.

"Claim Determination Period" means a calendar year or that portion of a calendar year during which the **covered person** for whom a claim is made has been covered under this **Plan**.

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a ***covered person*** for each claim determination period for the Allowable Expenses. If this ***Plan*** is secondary, the benefits paid under this ***Plan*** may be reduced so that the sum of benefits paid by all plans does not exceed 100% of total Allowable Expense.

If the rules set forth below would require this ***Plan*** to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this ***Plan***.

ORDER OF BENEFIT DETERMINATION

Each plan will make its claim payment according to the following order of benefit determination:

1. No Coordination of Benefits Provision
If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).
2. Member/Dependent
The plan which covers the claimant as a member (or named insured) pays as though no Other Plan existed. Remaining ***covered expenses*** are paid under a plan which covers the claimant as a ***dependent***.
3. Dependent Children of Parents not Separated or Divorced
The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.
4. Dependent Children of Separated or Divorced Parents
When parents are separated or divorced, the birthday rule does not apply, instead:
 - a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent, if any, pays fourth.
 - b. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody, if any, pays fourth.
5. Active/Inactive
The plan covering a person as an active (not laid off or retired) ***employee*** or as that person's ***dependent*** pays first. The plan covering that person as a laid off or retired ***employee***, or as that person's ***dependent*** pays second.
6. Limited Continuation of Coverage
If a person is covered under another group health plan, but is also covered under this ***Plan*** for continuation of coverage due to the Other Plan's limitations or exclusions, the Other Plan shall be primary.
7. Longer/Shorter Length of Coverage
If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

LIMITATIONS ON PAYMENTS

In no event shall the ***covered person*** recover under this ***Plan*** and all Other Plan(s) combined more than the total Allowable Expenses offered by this ***Plan*** and the Other Plan(s). Nothing contained in this section shall entitle the ***covered person*** to benefits in excess of the total ***maximum benefits*** of this ***Plan*** during the claim determination period. The ***covered person*** shall refund to the ***employer*** any excess it may have paid.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this *Coordination of Benefits* provision, the ***Plan*** may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information, regarding other insurance, with respect to any ***covered person***. Any person claiming benefits under this ***Plan*** shall furnish to the ***employer*** such information as may be necessary to implement the *Coordination of Benefits* provision.

FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this ***Plan*** in accordance with this provision have been made under any Other Plan, the ***employer*** shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this ***Plan*** and, to the extent of such payments, the ***employer*** shall be fully discharged from liability.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The *Plan* is administered through the Human Resources Department of the *employer*. The *employer* is the *plan administrator*. The *plan administrator* shall have full charge of the operation and management of the *Plan*. The *employer* has retained the services of an independent *claims processor* experienced in claims review.

The *employer* is the *named fiduciary* of the *Plan* except as noted herein. The *claims processor* is the *named fiduciary* of the *Plan* for post service claim (this may be different if an outside vendor is involved) appeals. As the *named fiduciary* for appeals, the *claims processor* maintains discretionary authority to review all denied claims under appeal for benefits under the *Plan*. The *employer* maintains discretionary authority to interpret the terms of the *Plan*, including but not limited to, determination of eligibility for and entitlement to *Plan* benefits in accordance with the terms of the *Plan*; any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

ASSIGNMENT

The *Plan* will pay benefits under this *Plan* to the *employee* unless payment has been assigned to a *professional provider* of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the *Plan* unless the *claims processor* is notified in writing of such assignment prior to payment hereunder.

This *Plan* will pay benefits to the responsible party of an *alternate recipient* as designated in a Qualified Medical Child Support Order.

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible *covered person* is entitled to receive benefits under this *Plan*. Such right to benefits is not transferable.

CLERICAL ERROR

No clerical error on the part of the *employer* or *claims processor* shall operate to defeat any of the rights, privileges, services, or benefits of any *employee* or any *dependent(s)* hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered. However, if more than six (6) months has elapsed prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

Any provision of the *Plan* which is in conflict with statutes which are applicable to this *Plan* is hereby amended to conform to the minimum requirements of said statute(s).

EFFECTIVE DATE OF THE PLAN

The original *effective date* of this *Plan* was September 1, 1992. The *effective date* of the modifications contained herein is March 1, 2003.

FREE CHOICE OF PROFESSIONAL PROVIDER

Nothing contained in this *Plan* shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to make a free choice of a *professional provider*.

INCAPACITY

If, in the opinion of the *employer*, a *covered person* for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the *Plan* of the qualification of a guardian or personal representative for his estate, the *employer* may on behalf of the *Plan*, at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the *Plan's* obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the *employer* or by the *employee* covered under this *Plan* shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this *Plan* or be used in defense to a claim unless they are contained in writing and signed by the *employer* or by the *covered person*, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the *Plan* prior to the expiration of sixty (60) days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the *Plan*. No such action shall be brought after the expiration of two (2) years from the date the expense was *incurred*, or one (1) year from the date a completed claim was filed, whichever occurs first.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the *employer* shall not be liable for any obligation of the *covered person incurred* in excess thereof. The *employer* shall not be liable for the negligence, wrongful act, or omission of any *professional provider*, or their employees, or any other person. The liability of the *Plan* shall be limited to the reasonable cost of *covered expenses* and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the *plan administrator* is unable to locate the *covered person* to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the *covered person* for the forfeited benefits within the time prescribed in the *Dental Claim Filing Procedure* section of this document.

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The ***Plan*** will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a State plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a ***covered person*** or in determining or making any payment of benefits to that individual. The ***Plan*** will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this ***Plan*** has a legal liability to make payments for the same services, supplies or treatment, payment under the ***Plan*** will be made in accordance with any State law which provides that the State has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the ***Plan***.

MISREPRESENTATION

If the ***covered person*** or anyone acting on behalf of a ***covered person*** makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the ***Plan***, or otherwise misleads the ***Plan***, the ***Plan*** shall be entitled to recover its damages, including legal fees, from the ***covered person***, or from any other person responsible for misleading the ***Plan***, and from the person for whom the benefits were provided. Any material misrepresentation on the part of the ***covered person*** in making application for coverage, or any application for reclassification thereof, or for service thereunder shall render the coverage under this ***Plan*** null and void.

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

The ***Plan***, at its own expense, shall have the right to require an examination of a person covered under this ***Plan*** when and as often as it may reasonably require during the pendency of a claim.

PLAN IS NOT A CONTRACT

The ***Plan*** shall not be deemed to constitute a contract between the ***employer*** and any ***employee*** or to be a consideration for, or an inducement or condition of, the employment of any ***employee***. Nothing in the ***Plan*** shall be deemed to give any ***employee*** the right to be retained in the service of the ***employer*** or to interfere with the right of the ***employer*** to terminate the employment of any ***employee*** at any time.

PLAN MODIFICATION AND AMENDMENT

The ***employer*** may modify or amend the ***Plan*** from time to time at its sole discretion, and such amendments or modifications which affect ***covered persons*** will be communicated to the ***covered persons***. Any such amendments shall be in writing, setting forth the modified provisions of the ***Plan***, the ***effective date*** of the modifications, and shall be signed by the ***employer's*** designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the ***Plan*** on file with the ***employer***, or a written copy thereof shall be deposited with such master copy of the ***Plan***. Appropriate filing and reporting of any such modification or amendment with governmental authorities and to ***covered persons*** shall be timely made by the ***employer***.

PLAN TERMINATION

The *employer* reserves the right to terminate the *Plan* at any time. Upon termination, the rights of the *covered persons* to benefits are limited to claims *incurred* up to the date of termination. Any termination of the *Plan* will be communicated to the *covered persons*.

PRONOUNS

All personal pronouns used in this *Plan* shall include either gender unless the context clearly indicates to the contrary.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the *Plan* in excess of the maximum amount of payment necessary, the *Plan* will have the right to recover these excess payments. If the Company makes any payment that, according to the terms of the *Plan*, should not have been made, the *Plan* may recover that incorrect payment, whether or not it was made due to the Company's own error, from the person or entity to whom it was made or from any other appropriate party.

STATUS CHANGE

If an *employee* or *dependent* has a status change while covered under this *Plan* (i.e. *dependent* to *employee*, COBRA to active) and no interruption in coverage has occurred, the *Plan* will provide continuous coverage with respect to any deductible(s), *coinsurance* and *maximum benefit*.

TIME EFFECTIVE

The effective time with respect to any dates used in the *Plan* shall be 12:00 a.m. (midnight) as may be legally in effect at the address of the *plan administrator*.

WORKERS' COMPENSATION NOT AFFECTED

This *Plan* is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

HIPAA PRIVACY

The following provisions are intended to comply with applicable *Plan* amendment requirements under Federal regulation implementing Section 264 of the Health Insurance Portability and Accountability Act of 1996 (*HIPAA*), and shall be construed as a part of the *Plan* document, effective April 14, 2004.

DISCLOSURE BY PLAN TO PLAN SPONSOR

The *Plan* may take the following actions only upon receipt of a *plan amendment certification*:

1. *Disclose protected health information* to the *plan sponsor*.
2. Provide for or permit the *disclosure* of *protected health information* to the *plan sponsor* by a *health insurance issuer* or *HMO* with respect to the *Plan*.

USE AND DISCLOSURE BY PLAN SPONSOR

The *plan sponsor* may *use* or *disclose protected health information* received from the *Plan* to the extent not inconsistent with the provisions of this *HIPAA PRIVACY* Section or the *privacy rule*.

OBLIGATIONS OF PLAN SPONSOR

The *plan sponsor* shall have the following obligations:

1. Ensure that:
 - a. Any agents (including a subcontractor) to whom it provides *protected health information* received from the *Plan* agree to the same restrictions and conditions that apply to the *plan sponsor* with respect to such information; and
 - b. Adequate separation between the *Plan* and the *plan sponsor* is established as provided below in *Access to Protected Health Information*.
2. Not *use* or further *disclose protected health information* received from the *Plan*, other than as permitted or required by the *Plan* documents or as *required by law*.
3. Not *use* or *disclose protected health information* received from the *Plan*:
 - a. For employment-related actions and decisions; or
 - b. In connection with any other benefit or employee benefit plan of the *plan sponsor*.
4. Report to the *Plan* any *use* or *disclosure* of the *protected health information* received from the *Plan* that is inconsistent with the *use* or *disclosure* provided for of which it becomes aware.

5. Make available *protected health information* received from the *Plan*, as and to the extent required by the *privacy rule*:
 - a. For access to the *individual*;
 - b. For amendment and incorporate any amendments to *protected health information* received from the *Plan*; and
 - c. To provide an accounting of *disclosures*.
6. Make its internal practices, books, and records relating to the *use* and *disclosure* of *protected health information* received from the *Plan* available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the *Plan* with the *privacy rule*.
7. Return or destroy all *protected health information* received from the *Plan* that the *plan sponsor* still maintains in any form and retain no copies when no longer needed for the purpose for which the *disclosure* by the *Plan* was made, but if such return or destruction is not feasible, limit further *uses* and *disclosures* to those purposes that make the return or destruction of the information infeasible.
8. Provide *protected health information* only to those individuals, under the control of the *plan sponsor* who perform administrative functions for the *Plan*; (i.e. eligibility, enrollment, payroll deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use *protected health information* for any reason other than for *Plan* administrative functions nor to release *protected health information* to an unauthorized individual.
9. Provide *protected health information* only to those entities required to receive the information in order to maintain the *Plan* (i.e. claim administrator, case management vendor, pharmacy benefit manager, claim subrogation, vendor, claim auditor, network manager, stoploss insurance carrier, insurance broker/consultant, and any other entity subcontracted to assist in administering the *Plan*).
10. Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.

EXCEPTIONS

Notwithstanding any other provision of this *HIPAA PRIVACY* Section, the *Plan* (or a *health insurance issuer* or *HMO* with respect to the *Plan*) may:

1. ***Disclose summary health information*** to the *plan sponsor*:
 - a. If the *plan sponsor* requests it for the purpose of:
 - i. Obtaining premium bids from *health plans* for providing health insurance coverage under the *Plan*; or
 - ii. Modifying, amending, or terminating the *Plan*.
2. ***Disclose*** to the *plan sponsor* information on whether the *individual* is participating in the *Plan*, or is enrolled in or has disenrolled from a *health insurance issuer* or *HMO* offered by the *Plan*;
3. ***Use or disclose protected health information***:
 - a. With (and consistent with) a valid authorization obtained in accordance with the *privacy rule*;
 - b. To carry out *treatment, payment, or health care operations* in accordance with the *privacy rule*; or
 - c. As otherwise permitted or required by the *privacy rule*.

DEFINITIONS

As used in this *HIPAA PRIVACY* Section, the terms shown in ***bold and italics*** shall have the following meanings, or if not defined below, shall have the meanings as defined in the ***privacy rule*** unless the context plainly requires otherwise.

Plan

The Clark State Community College Dental Benefit Plan

Plan Sponsor

The Clark State Community College

Privacy Rule

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulation concerning privacy of individually identifiable health information, as published in 65 Fed. Reg. 82461 (Dec. 28, 2000) and as modified and published in 67 Fed. Reg. 53181 (Aug. 14, 2002).

Required by Law

The same meaning as the term “required by law” as defined in 45 CFR 164.501, to the extent not preempted by ERISA or other Federal law.

DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in *bold and italics* throughout the document:

Accident

An unforeseen event resulting in *injury*.

Active Service

An *employee* performing all of the regular duties of his job while in *active service* with the *employer*. On any day, an *employee* will be considered in *active service* if the *employee* performed the regular duties of his job on the last scheduled work day.

Actively at Work; Active Work

The expenditure of time and energy in the service of the *employer*, except that an *employee* shall be deemed *actively at work* on each day of regular paid vacation, or on a regular non-working day, on which he is not disabled, provided he was *actively at work* on the last preceding regular working day.

Alternate Recipient

Any child of an *employee* or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this *Plan*.

Claims Processor

CoreSource, Inc.

Close Relative

The *employee's* spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the *employee's* spouse.

Coinsurance

The benefit percentage of *covered expenses* payable by the *Plan* for benefits that are provided under the *Plan*. The *coinsurance* is applied to *covered expenses* after the deductible(s) have been met, if applicable.

Covered Expenses

Medically necessary services, supplies or treatments that are recommended or provided by a *professional provider* for the treatment of an *illness* or *injury* and that are not specifically excluded from coverage herein.

Covered Person

A person who is eligible for coverage under this *Plan*, or becomes eligible at a later date, and for whom the coverage provided by this *Plan* is in effect.

Customary and Reasonable Amount

The fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is ***incurred*** and is comparable in severity and nature to the ***illness*** or ***injury***. Due consideration shall be given to any dental complications or unusual circumstances which require additional time, skill or experience. The ***customary and reasonable amount*** is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges.

Dentist

A Doctor of Dental Medicine (D.M.D.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Medicine (M.D.), or a Doctor of Osteopathy (D.O.), other than a ***close relative*** of the ***covered person***, who is practicing within the scope of his license.

Dependent

A ***dependent*** is:

1. An ***employee's*** spouse. The term "spouse" means the spouse of the ***employee*** under a legally valid existing marriage between persons of the opposite sex, unless court ordered separation exists.
2. An ***employee's*** child. The term "child" means the ***employee's*** natural child, stepchild, legally adopted child, and a child for whom the ***employee*** or covered spouse has been appointed legal guardian, provided:
 - a. The child is less than twenty-three (23) years of age, and;
 - b. The child is unmarried, and;
 - c. The child is not regularly employed by one or more employers on a full-time basis, exclusive of scheduled vacation periods.
3. An eligible child shall also include any other child of an ***employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan***, even if the child is not residing in the ***employee's*** household. Such child shall be referred to as an ***alternate recipient***. ***Alternate recipients*** are eligible for coverage regardless of whether the ***employee*** elects coverage for himself. An application for enrollment must be submitted to the ***employer*** for coverage under this ***Plan***. The ***employer/plan administrator*** shall establish written procedures for determining whether a medical child support order is a QMCSO and for administering the provision of benefits under the ***Plan*** pursuant to a valid QMCSO. The ***employer/plan administrator*** reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.
4. Adopted children, who are less than 18 years of age at the time of adoption, shall be considered eligible from the date the child is ***placed for adoption***.
5. Upon written notice to the ***employer***, a child who has reached his or her twenty-third (23rd) birthday and is principally dependent upon the ***employee*** for support and maintenance, may also be included herein as an eligible ***dependent*** until the child's twenty-fifth (25th) birthday, provided such child is unmarried, and is a ***full-time student*** in a secondary school, accredited college, university or institution of higher learning. It is the ***employee's*** responsibility to provide the ***claims processor*** with proof of ***full-time student status*** for each semester. The ***employee*** must notify the ***employer*** when the ***dependent*** is no longer a ***full-time student***.

6. A child who is unmarried, incapable of self-sustaining employment, and dependent upon the **employee** for support due to a mental and/or physical disability, and who was covered under the **Plan** prior to reaching the maximum age limit or due to other loss of **dependent's** eligibility, will remain eligible for coverage under this **Plan** beyond the date coverage would otherwise be lost.

For further information regarding eligibility for **dependents**, refer to *Eligibility, Enrollment and Effective Date, Dependent(s) Eligibility*.

Effective Date

The date of this **Plan** or the date on which the **covered person's** coverage commences, whichever occurs later.

Employee

A person directly involved in the regular business of and compensated for services, as reported on the individual's annual W-2 form, by the **employer**, who is regularly scheduled to work not less than 960 hours per year on a **full-time** status basis.

Employer

The **employer** is The Clark State Community College.

Enrollment Date

A **covered person's enrollment date** is the first day of any applicable service waiting period or the date of hire.

Experimental/Investigational

Services, supplies, drugs and treatments which do not constitute accepted dental practice properly within the range of appropriate dental practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the dental community or government oversight agencies at the time services were rendered.

The **claims processor, named fiduciary for post-service claims, employer/plan administrator**, or their designee must make an independent evaluation of the **experimental/non-experimental** standings of specific technologies. The **claims processor, named fiduciary for post-service claims, employer/plan administrator** or their designee shall be guided by a reasonable interpretation of **Plan** provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The **claims processor, named fiduciary for post-service claims, employer/plan administrator** or their designee will be guided by the following examples of **experimental** services and supplies:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, dental treatment or procedure, was not reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
3. If "reliable evidence" shows that the drug, device, dental treatment or procedure is the subject of on-going Phase I or Phase II clinical trials, is in the research, **experimental**, study or **investigational** arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety or its efficacy as compared with a standard means of treatment or diagnosis; or

4. If “reliable evidence” shows that prevailing opinion among experts regarding the drug, device, dental treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

“Reliable evidence” shall mean only published reports and articles in the authoritative dental and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, dental treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, dental treatment or procedure.

Full-time

Employees who are regularly scheduled to work not less than 960 hours per year.

Full-time Student or Full-time Student Status

An ***employee's dependent*** child who is enrolled in and regularly attending secondary school, an accredited college, university, or institution of higher learning for the minimum number of credit hours required by that institution in order to maintain ***full-time student status***.

Illness

A bodily disorder, disease, physical sickness.

Incurred or Incurred Date

With respect to a ***covered expense***, the date the services, supplies or treatment are provided.

Injury

A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. ***Injury*** does not include ***illness*** or infection of a cut or wound, or self-inflicted ***injury***.

Layoff

A period of time during which the ***employee***, at the ***employer's*** request, does not work for the ***employer***, but which is of a stated or limited duration and after which time the ***employee*** is expected to return to ***full-time, active work***. Layoffs will otherwise be in accordance with the ***employer's*** standard personnel practices and policies.

Leave of Absence

A period of time during which the ***employee*** does not work, but which is of a stated duration after which time the ***employee*** is expected to return to ***active work***.

Maximum Benefit

Any one of the following, or any combination of the following:

1. The maximum amount paid by this ***Plan*** for any one ***covered person*** during the entire time he is covered by this ***Plan***.

2. The maximum amount paid by this **Plan** for any one **covered person** for a particular **covered expense**. The maximum amount can be for:
 - a. The entire time the **covered person** is covered under this **Plan**, or
 - b. A specified period of time, such as a calendar year.
3. The maximum number as outlined in the **Plan** as a **covered expense**. The maximum number relates to the number of treatments during a specified period of time.

Medically Necessary (or Medical Necessity)

Service, supply or treatment which is determined by the **claims processor, named fiduciary for post-service claims, employer/plan administrator** or their designee to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the **covered person's illness or injury** and which could not have been omitted without adversely affecting the **covered person's** condition or the quality of the care rendered; and
2. Supplied or performed in accordance with current standards of dental practice within the United States; and
3. Not primarily for the convenience of the **covered person** or the **covered person's** family or **professional provider**; and
4. Is an appropriate supply or level of service that safely can be provided; and
5. Is recommended or approved by the attending **professional provider**.

The fact that a **professional provider** may prescribe, order, recommend, perform or approve a service, supply or treatment does not, in and of itself, make the service, supply or treatment **medically necessary** and the **claims processor, named fiduciary for post-service claims, employer/plan administrator** or its designee, may request and rely upon the opinion of a **dentist or dentists**. The determination of the **claims processor, named fiduciary for post-service claims, employer/plan administrator** or its designee shall be final and binding.

Medicare

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; and Part C, Miscellaneous provisions regarding both programs; and including any subsequent changes or additions to those programs.

Named Fiduciary for Post-Service Claim Appeals

CoreSource, Inc.

Placed For Adoption

The date the **employee** assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan

"**Plan**" refers to the benefits and provisions for payment of same as described herein.

Plan Administrator

The ***plan administrator*** is responsible for the day-to-day functions and management of the ***Plan***. The ***plan administrator*** is the ***employer***.

Professional Provider

A person or other entity licensed where required and performed services within the scope of such license. The covered ***professional providers*** include, but are not limited to:

Dental Hygienist

Dentist

Physician

Relevant Information

Relevant information, when used in connection with a claim for benefits or a claim appeal, means any document, record or other information:

1. Relied on in making the benefit determination; or
2. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or
3. That demonstrates compliance with the duties to make benefit decisions in accordance with ***Plan*** documents and to make consistent decisions; or
4. That constitutes a statement of policy or guidance for the ***Plan*** concerning the denied treatment or benefit for the ***covered person's*** diagnosis, even if not relied upon.

Total Disability or Totally Disabled

The ***employee*** is prevented from engaging in his regular, customary occupation or from an occupation for which he or she becomes qualified by training or experience, and is performing no work of any kind for compensation or profit; or a ***dependent*** is prevented from engaging in all of the normal activities of a person of like age and sex who is in good health.