

**DENTAL BENEFITS PLAN  
FOR**

**City of Plano Risk Pool**



**GROUP NUMBER: 704335**

**EFFECTIVE DATE: January 1, 2011**



## **Introduction**

Coverage is subject to the terms, conditions, exclusions, and limitations of the Plan. As a summary Plan Description ("SPD"), this document describes the provisions of Coverage under the Plan but does not constitute the entire Plan. For Dental Services rendered after the effective date of the Plan, this SPD replaces and supersedes any SPD, which may have been previously issued to you by the Plan Sponsor. Any subsequent SPDs issued to you by the Plan Sponsor will in turn supersede this SPD.

### **How To Use This SPD**

This SPD should be read and re-read in its entirety. Many of the provisions of this SPD are interrelated; therefore, reading just one or two provisions may not give you an accurate impression of your Coverage.

Your SPD may be modified by the attachment of Amendments. Please read the provision described in these documents to determine the way in which provisions in this SPD may have been changed.

Many words used in this SPD have special meanings. These words will appear capitalized and are defined for you in the Section entitled "Definitions". By reviewing these definitions, you will have a clearer understanding of your SPD.

From time to time, the Plan may be amended. When that happens, a new SPD or Amendment pages for this SPD will be sent to you. Your SPD should be kept in a safe place for your future reference.

### **Dental Services Covered Under the Plan**

Only Necessary Dental Services are Covered under the Plan. The fact that a Dentist has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease does not mean that the procedure or treatment is Covered under the Plan.

The Plan Sponsor has sole and exclusive discretion in interpreting the benefits Covered under the Plan and the other terms, conditions, limitations and exclusions set out in the Plan and in making factual determinations related to the Plan and its benefits. The Plan Sponsor may, from time to time, delegate discretionary authority to other persons or entities providing services in regard to the Plan.

The Plan Sponsor reserves the right to change, interpret, modify, withdraw or add benefits or terminate the Plan, in its sole discretion, as permitted by law, without the approval of Covered Persons. No person or entity has any authority to make any oral changes to amendments to the Plan.

The Plan Sponsor may, in its sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, including claims processing and utilization management services. The identity of the service providers and the nature of the services provided may be changed from time to time in the Plan Sponsor's sole discretion and without prior notice to or approval by Covered Persons. You must cooperate with those persons or entities in the performance of their responsibilities.

Similarly, the Plan Sponsor may, from time to time, require additional information from you to verify your eligibility or your right to receive Coverage for services under the Plan. You are obligated to provide this information. Failure to provide required information could result in Coverage being delayed or denied.

### **Identification ("ID") Card**

You must show your ID card every time you request Dental Services. If you do not show your card, the providers have no way of knowing that you are Covered under a Plan issued by the Plan Sponsor.

### **Contact the Plan Administrator**

Throughout this SPD you will find statements that encourage you to contact the Plan Administrator for further information. Whenever you have a question or concern regarding Dental Services or any required procedure, please contact the Plan Administrator or United HealthCare at the telephone number stated on your ID card.

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## SECTION 1 - DEFINITIONS

This Section defines the terms used throughout this SPD and is not intended to describe Covered or uncovered services.

**"Amendment"** - any attached description of additional or alternative provisions to the Plan. Amendments are subject to all conditions, limitations and exclusions of the Plan except for those which are specifically amended.

**"Annual Deductible"** - the amount a Covered Person must pay for Dental Services in a calendar year before the Plan Sponsor will begin paying for Benefits in that calendar year.

**"Annual Maximum Benefit"** - the maximum amount paid for Covered Dental Services during a calendar year for a Covered Person under the Plan or any Plan covering the Enrolling Group that replaces the Plan. The Annual Maximum Benefit is stated in the Schedule of Benefits.

**"Congenital Anomaly"** - a physical developmental defect that is present at birth and identified within the first twelve months from birth.

**"Copayment"** - the charge that you are required to pay for certain Dental Services provided under the Plan. A Copayment may either be a defined dollar amount or a percentage of Eligible Expenses. You are responsible for the payment of any Copayment directly to the provider of the Dental Service at the time of service or when billed by the provider.

**"Coverage" or "Covered"** - the entitlement by a Covered Person to reimbursement for expenses incurred for Dental Services covered under the Plan, subject to the terms, conditions, limitations and exclusions of the Plan. Dental Services must be provided: (1) when the Plan is in effect; and (2) prior to the date that any of the individual termination conditions as stated in the Section entitled Termination of Coverage occur; and (3) only when the recipient is a Covered Person and meets all eligibility requirements specified in the Plan.

**"Covered Person"** - either the Subscriber or an Enrolled Dependent while Coverage of such person under the Plan is in effect. References to "you" and "your" throughout this SPD are references to a Covered Person.

**"Dental Service" or "Dental Procedures"** - dental care or treatment provided by a Dentist to a Covered Person while the Plan is in effect, provided such care or treatment is recognized by the Plan Administrator as a generally accepted form of care or treatment according to prevailing standards of dental practice.

**"Dentist"** - any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render dental services, perform dental surgery or administer anesthetics for dental surgery.

**"Dependent"** - the Participant's legal spouse (to include common law, provided such marriage is recognized as legal by the state in which the Employee resides.) Common law marriage in the state of Texas is known as an "informal marriage." The Employee must furnish to the Plan Administrator the necessary documentation that is required by the state in which the Employee resides to formalize the common law marriage. Such evidence as required by the state in which the Employee resides may include, but is not limited to, a marital agreement, a declaration of informal marriage form as required by the state of Texas, Federal Income Tax Returns declaring marriage, insurance policies declaring each other as spouse, etc." or an unmarried dependent child of the Participant or the Participant's spouse. The term child includes any of the following:

- A natural child.
- A stepchild that resides with the employee.
- A legally adopted child. eligible from the date the Employee becomes a party in a suit for adoption;

- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Participant or the Participant's spouse.
- Please be advised that coverage of a grandchild under the City of Plano's medical plan through United HealthCare is dependent on satisfying certain criteria. Specifically, the grandchild and grandparent must have a parent-child relationship.

In other words, the grandchild must reside in the same household as the grandparent and the relationship must be defined by one of the following:

1. Legal adoption.
2. Placement for adoption.
3. Legal guardianship.
4. Court or administrative order.

Please be aware that United HealthCare may at any time request documentation of proof that one of the above defined relationship exists between grandparent and grandchild; and

- foster child; however, the Plan requires that the child reside with and receive principal support from the Employee.

An Employee's unmarried child age 26 or older who is:

1. totally disabled due to mental or physical reasons; and
2. becomes totally disabled while covered as a dependent under A above; and
3. chiefly dependent on the Employee for support and maintenance. Proof of such incapacity and dependency needs to be furnished to the Plan within 31 days of the child's attainment of 26 and subsequently as may be required by the Plan but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Total Disability with respect to a dependent child means the inability of the individual to engage in the normal occupational, domestic, or social activities of a person of like age and sex in good health.

For the purposes of this Plan, the definition of Dependent does not include any individual who is a member of the armed forces of any country, any resident of a country other than the United States, or any child placed in an Employee's home by a welfare agency if such agency retains control of and provides maintenance of such Child. The Employer reserves the right to require whatever documentation is necessary to satisfy that the individual has met all the requirements of a Dependent.

A Dependent of a Retired Employee who meets the above definition of dependent is considered an eligible Dependent under this Plan.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any unmarried dependent child under 26 years of age.

The Participant must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. We are responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

Dependents are not automatically covered unless added by the HR Department.

**"Eligible Expenses"** - Eligible Expenses for Covered Dental Services, incurred while the Plan is in effect, are determined as stated below:

1. For Network Benefits, when Covered Dental Services are received from Network providers, Eligible Expenses are the Plan Administrator's contracted fee(s) for Dental Services with that provider.
2. For Non-Network Benefits, when Covered Dental Services are received from Non-Network providers, Eligible Expenses are the Usual and Customary fees as defined below.

Eligible Expenses must not exceed the fees that the provider would charge any similarly situated payor for the same services. In the event that a Non-Network provider routinely waives Copayments and/or the Annual Deductible for Non-Network Benefits, Dental Services for which the Copayments and/or the Annual Deductible are waived are not considered to be Eligible Expenses.

**"Eligible Person"** - (1) an employee of the Plan Sponsor; or (2) other person who meets the eligibility requirements specified in both the application and the Plan.

**"Emergency"** - a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

**"Enrolled Dependent"** - a Dependent who is properly enrolled for Coverage under the Plan.

**"Experimental, Investigational or Unproven Services"** - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company, on behalf of the Plan Administrator, makes a determination regarding coverage in a particular case, is determined to be:

- A. Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- B. Subject to review and approval by any institutional review board for the proposed use; or
- C. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- D. Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

**"Necessary"** - dental care services and supplies which are determined by the Company, on behalf of the Plan Administrator, to be appropriate, and

- A. necessary to meet the basic dental needs of the Covered Person; and
- B. rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service; and
- C. consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Company; and
- D. consistent with the diagnosis of the condition; and
- E. required for reasons other than the convenience of the Covered Person or his or her Dentist; and
- F. demonstrated through prevailing peer-reviewed medical and/or dental literature to be either:
  1. safe and effective for treating or diagnosing the condition or Sickness for which their use is proposed, or,
  2. safe with promising efficacy
    - a. for treating a life threatening dental disease or condition,

- b. in a clinically controlled research setting; and
- c. using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life threatening" is used to describe a dental disease or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dentist has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this SPD. The definition of Necessary used in this SPD relates only to Coverage and differs from the way in which a Dentist engaged in the practice of dentistry may define necessary.

**"Open Enrollment Period"** - after the Initial Eligibility Period, a period of time determined by the Plan Administrator, during which Eligible Persons may enroll themselves and Dependents under the Plan.

**"Physician"** - any Doctor of Medicine, "M.D.," or Doctor of Osteopathy, "D.O.," who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

**"Plan" – City of Plano Risk Pool.**

**"Procedure in Progress"** - all treatment for Covered Services that results from a recommendation and an exam by a Dentist. A treatment procedure will be considered to start on the date it is initiated and will end when the treatment is completed.

**"Subscriber"** - an Eligible Person who is properly enrolled for Coverage under the Plan. The Subscriber is the person on whose behalf coverage under the Plan is provided.

**"Usual and Customary"** - Usual and Customary fees are calculated by the Plan Administrator based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the provider would charge any similarly situated payor for the same services. In the event that a provider routinely waives Copayments and/or the Annual Deductible for benefits, Dental Services for which the Copayments and/or the Annual Deductible are waived are not considered to be usual and customary.

Usual and Customary fees are determined solely in accordance with the Plan Administrator's reimbursement policy guidelines. The Plan Administrator's reimbursement policy guidelines are developed by the Plan Administrator, in its discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association);
- As reported by generally recognized professionals or publications;
- As utilized for Medicare;
- As determined by medical or dental staff and outside medical or dental consultants;
- Pursuant to other appropriate source or determination accepted by the Plan Administrator.

## **SECTION 2 - ENROLLMENT AND EFFECTIVE DATE OF COVERAGE**

**Section 2.1 Enrollment.** Eligible Persons may enroll themselves and their Dependents for Coverage under the Plan during the Initial Eligibility Period or during an Open Enrollment Period, determined by the Plan Sponsor, by submitting a form provided by the Plan Administrator. In addition, new Eligible Persons and new Dependents may be enrolled as described below. Dependents of an Eligible Person may not be enrolled unless the Eligible Person is also enrolled for Coverage under the Plan.

If both spouses are eligible Employees of the Plan Sponsor, each may enroll as a Subscriber but neither may enroll as a dependent. If both parents of an eligible Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

**Section 2.2 Effective Date of Coverage.** Coverage for you and any of your Dependents is effective on January 1, 2011. In no event is there Coverage for Dental Services rendered or delivered before the effective date of Coverage.

**Section 2.3 Coverage for a Newly Eligible Person.** Coverage for you and any of your Dependents shall take effect on the date the Eligible person joins the Enrolling Group. Coverage is effective only if the Company receives any required contributions toward the coverage and a properly completed enrollment form within 31 days of the date you first become eligible.

**Section 2.4 Coverage for a Newly Eligible Dependent.** Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption, court or administrative order, marriage or a qualifying event as described under Section 125 of the IRS, shall take effect on the date of the event. Coverage is effective only if the Plan Sponsor receives any required contribution for coverage and is notified of the event within 31 days.

**Section 2.5 Special Enrollment Period.** An Eligible Person and/or Dependent who did not enroll for Coverage under the Plan during the Initial Eligibility Period or Open Enrollment Period may enroll for Coverage during a special enrollment period. A special enrollment period is available if the following conditions are met: (a) the Eligible Person and/or Dependent had existing health coverage under another plan at the time of the Initial Eligibility Period or Open Enrollment Period and (b) Coverage under the prior plan was terminated as a result of loss of eligibility (including, without limitation, legal separation, divorce or death), termination of employer contributions, or in the case of COBRA continuation coverage, the coverage was exhausted. A special enrollment period is not available if coverage under the prior plan was terminated for cause or as a result of failure to pay any required contributions on a timely basis. Coverage under the Plan is effective only if the Plan Administrator receives any required contribution for coverage and a properly completed enrollment form within 31 days of the date coverage under the prior plan terminated.

A special enrollment period is also available for an Eligible Person and for any Dependent whose status as a Dependent is affected by a marriage, birth, placement for adoption or adoption, as required by federal law. In such cases you must submit the required contribution for coverage and a properly completed enrollment form within 31 days of the marriage, birth, placement for adoption or adoption.

## SECTION 3 - TERMINATION OF COVERAGE

**Section 3.1 Conditions for Termination of a Covered Person's Coverage Under the Plan.** The Plan Sponsor may, at any time, discontinue this benefit plan and/or all similar benefit plans for the reasons specified in the Plan. When your Coverage terminates, you may have continuation as described in the Section entitled Continuation of Coverage or as provided under other applicable federal and/or state law.

Your Coverage, including coverage for Dental Services rendered after the date of termination for dental conditions arising prior to the date of termination, shall automatically terminate on the earliest of the dates specified below.

- A. The date the entire Plan is terminated.
- B. The last day of the calendar month in which you cease to be eligible as a Subscriber or Enrolled Dependent.
- C. The date the Plan Administrator receives written notice from the Subscriber instructing the Plan Administrator to terminate Coverage of the Subscriber or any Covered Person, or the date requested in such notice, if later.

- H. **Section 3.2 Extended Coverage for Handicapped Dependent Children.** Coverage of an unmarried Enrolled Dependent who is incapable of self-support because of mental retardation or physical handicap will be continued beyond the limiting age specified in the Plan provided that:
- A. the Enrolled Dependent becomes so incapacitated prior to attainment of the limiting age; and
  - B. the Enrolled Dependent is chiefly dependent upon the Subscriber for support and maintenance; and
  - C. proof of such incapacity and dependence is furnished to the Plan Administrator within 31 days of the date the Subscriber receives a request for such proof from the Plan Administrator; and
  - D. payment of any required contribution for the Enrolled Dependent is continued.

Coverage will be continued so long as the Enrolled Dependent continues to be so incapacitated and dependent, unless otherwise terminated in accordance with the terms of the Plan. Before granting this extension, the Plan Administrator may reasonably require that the Enrolled Dependent be examined at the Plan Sponsor's expense by a Physician designated by the Plan Administrator. At reasonable intervals, the Plan Administrator may require satisfactory proof of the Enrolled Dependent's continued incapacity and dependency, including medical examinations at the Plan Sponsor's expense. Such proof will not be required more often than once a year. Failure to provide such satisfactory proof within 31 days of the request by the Plan Administrator will result in termination of the Enrolled dependent's coverage under the Plan.

**Section 3.3 Extended Coverage.** A 3 month temporary extension of Coverage, only for the services shown below given in connection with a Procedure in Progress, will be granted to a Covered Person on the date the person's Coverage is terminated if termination is not voluntary. Benefits will be extended until the earlier of (a) the end of the 30 day period or (b) the date the Covered Person becomes covered under a succeeding Plan or contract providing coverage or services for similar dental procedures.

Benefits will be Covered for: (a) a Procedure in Progress or dental procedure that was recommended in writing and began, in connection with a specific dental disease of a Covered Person while the Plan was in effect, by the attending Dentist; (b) an appliance, or modification to an appliance, for which the impression was taken prior to the termination of Coverage; or (c) a crown, bridge or gold restoration, for which the tooth was prepared prior to the termination of Coverage.

**Section 3.4 Payment and Reimbursement Upon Termination.** Termination of Coverage shall not affect any request for reimbursement of Eligible Expenses for Dental Services rendered prior to the effective date of termination. Your request for reimbursement must be furnished as required in the Section entitled Reimbursement.

## **SECTION 4 - REIMBURSEMENT**

**Section 4.1 Reimbursement of Eligible Expenses.** The Plan Sponsor shall reimburse you for Eligible Expenses subject to the terms, conditions, exclusions and limitations of the Plan and as described below.

**Section 4.2 Filing Claims for Reimbursement of Eligible Expenses.** You are responsible for sending a request for reimbursement to the Company office, on a form provided by or satisfactory to the Company. Requests for reimbursement should be submitted within 90 days after date of service. Unless you are legally incapacitated, failure to provide this information to the Company within 1 year of the date of service shall cancel or reduce Coverage for the Dental Service.

Subject to written authorization from a Subscriber, all or a portion of any Eligible Expenses due may be paid directly to the provider of the Dental Service instead of being paid to the Subscriber.

**Claim Forms.** It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- A. Your name and address
- B. Patient's name and age
- C. Number stated on your ID card
- D. The name and address of the provider of the service(s)
- E. A diagnosis from the Dentist including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim
- F. Radiographs, lab or Hospital reports
- G. Casts, molds or study models
- H. Itemized bill which includes the CPT or ADA codes or description of each charge
- I. The date the dental disease began.
- J. A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, you may request one from the Plan Administrator at the telephone number stated on your ID Card and a claim form will be sent to you. The forms are also available online. If you do not receive the claim form within 10 days of your request, send in the proof of loss with the information stated above.

**Proof of Loss.** Written proof of loss should be given to the Company within 90 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the Plan Sponsor will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service.

**Payment of Claims.** Benefits are payable within 60 days after the Company receives acceptable proof of loss. Benefits will be paid to you unless:

- A. the provider notifies the Company that your signature is on file assigning benefits directly to that provider; or
- B. you make a written request assigning benefits to the provider at the time the claim is submitted.

**Section 4.3 Limitation of Action for Reimbursement.** You do not have the right to bring any legal proceeding or action against the Plan Sponsor to recover reimbursement until 30 days after you have properly submitted a request for reimbursement, as described above. If you do not bring such legal proceeding or action within 3 years of the expiration date, you forfeit your rights to bring any action against the Plan Sponsor.

## **SECTION 5 - COMPLAINT PROCEDURES**

### **Section 5.1 Benefit Determinations.**

#### **A. Post-Service Claims**

Post-Service Claims are those claims that are filed for payment of benefits after dental care has been received. If your post-service claim is denied, you will receive a written notice from United HealthCare within 30 days of receipt of the claim, as long as all needed information was provided with the claim. United HealthCare will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, United HealthCare will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

#### **B. Pre-Service Claims**

Pre-service claims are those claims that require notification or approval prior to receiving medical care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from United HealthCare within 15 days of receipt of the claim. If you filed a pre-service claim improperly, United HealthCare will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, United HealthCare will notify you of the information needed within 15 days after the claim was received, and may request a one time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, United HealthCare will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

#### **C. Urgent Claims that Require Immediate Action**

Urgent care claims are those claims that require notification or approval prior to receiving dental care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain. In these situations:

- i. You will receive notice of the benefit determination in writing or electronically within 72-hours after United HealthCare receives all necessary information, taking into account the seriousness of your condition.
- ii. Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an urgent care claim improperly, United HealthCare will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, United HealthCare will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- i. United HealthCare's receipt of the requested information; or
- ii. The end of the 48 hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

#### **D. Concurrent Care Claims**

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. United HealthCare will make a determination on your request for the extended

treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

**Section 5.2 Questions and Appeals.** This section provides you with information to help you with the following:

- A. You have a question or concern about covered dental services or your benefits.
- B. You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and you wish to appeal such determination.

**What to do first** - If your question or concern is about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in Section 5, you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of United HealthCare.

If you are appealing an Urgent Care Claim denial, please refer to the "Urgent Claim Appeals that Require Immediate Action" section below and contact Customer Service immediately.

The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

**Section 5.3 How to Appeal a Claim Decision.** If you disagree with a claim determination after following the above steps, you can contact United HealthCare in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- A. The patient's name and the identification number from the ID card.
- B. The date(s) of medical service(s).
- C. The provider's name.
- D. The reason you believe the claim should be paid.
- E. Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to United HealthCare within 180 days after you receive the claim denial.

**Section 5.4 Appeal Process.** A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. United HealthCare may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

**Section 5.5 Appeals Determinations for Pre-Service and Post-Service Claim Appeals.** You will be provided written or electronic notification of decision on your appeal as follows:

- A. For appeals of pre-service claims (as defined in Section 5.1), the first level appeal will be conducted and you will be notified by United HealthCare of the decision within 15 days from receipt of a request

for appeal of a denied claim. The second level appeal will be conducted and you will be notified by United HealthCare of the decision within 15 days from receipt of a request for review of the first level appeal decision.

- B. For appeals of post-service claims (as defined in Section 5.1), the first level appeal will be conducted and you will be notified by United HealthCare of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by United HealthCare of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see "Urgent Claim Appeals That Require Immediate Action" below.

If you are not satisfied with the first level appeal decision of United HealthCare, you have the right to request a second level appeal from United HealthCare. Your second level appeal request must be submitted to United HealthCare within 60 days from receipt of first level appeal decision.

United HealthCare has the exclusive right to interpret and administer the provisions of the Plan. United HealthCare's decisions are conclusive and binding. Please note that the United HealthCare's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

**Section 5.6 Urgent Claim Appeals that Require Immediate Action.** Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

The appeal does not need to be submitted in writing. You or your Physician should call United HealthCare as soon as possible. United HealthCare will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, the Plan Sponsor has delegated to United HealthCare the exclusive right to interpret and administer the provisions of the Plan. United HealthCare's decisions are conclusive and binding.

## **SECTION 6 - GENERAL PROVISIONS**

**Section 6.1 Records.** You must furnish the Plan Administrator with all information and proofs that it may reasonably require regarding any matters pertaining to the Plan.

By accepting Coverage under the Plan, you authorize and direct any person or institution that has provided services to you, to furnish the Plan Administrator any and all information and records or copies of records relating to the services provided to you. The Plan Administrator has the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

The Plan Administrator agrees that such information and records will be considered confidential. The Plan Administrator has the right to release any and all records concerning dental care services which are necessary to implement and administer the terms of the Plan or for appropriate review or quality assessment.

The Plan Administrator is permitted to charge you reasonable fees to cover costs for completing requested dental records or forms that you have requested.

In some cases, the Plan Administrator will designate other persons or entities to request records or information from or related to you and to release those records as necessary. The Plan Administrator's designees have the same rights to this information, as does the Plan Administrator or Plan Sponsor.

**Section 6.2 Examination of Covered Persons.** In the event of a question or dispute concerning Coverage for Dental Services, the Company may reasonably require that a Dentist acceptable to the Plan Administrator examine you at the Plan Sponsor's expense.

**Section 6.3 Clerical Error.** If a clerical error or other mistake occurs, that error shall not deprive you of Coverage under the Plan. A clerical error also does not create a right to benefits.

## **SECTION 7 - COORDINATION OF BENEFITS**

**Section 7.1 Coordination of Benefits Applicability.** This coordination of benefits (COB) provision applies when a person has dental coverage under more than one Coverage Plan. "Coverage Plan" is defined below.

The order of benefit determination rules below determine which Coverage Plan will pay as the primary Coverage Plan. The primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A secondary Coverage Plan pays after the primary Coverage Plan and may reduce the benefits it pays so that payments from all group Coverage Plans do not exceed 100% of the total allowable expense.

**Section 7.2 Definitions.** For purposes of this Section, Coordination of Benefits, terms are defined as follows:

- A. A "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
  - 1. "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
  - 2. "Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.

- B. The order of benefit determination rules determine whether this Coverage Plan is a "primary Coverage Plan" or "secondary Coverage Plan" when compared to another Coverage Plan covering the person.

When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the primary Coverage Plan's benefits.

- C. "Allowable expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

1. If a person is covered by 2 or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.
  2. If a person is covered by 2 or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
  3. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the primary Coverage Plan's payment arrangements shall be the allowable expense for all Coverage Plans.
  4. The amount a benefit is reduced by the primary Coverage Plan because a covered person does not comply with the Coverage Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
- D. "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.
- E. "Closed panel Coverage Plan" is a Coverage Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other provider, except in cases of emergency or referral by a panel member.
- F. "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

**Section 7.3 Order of Benefit Determination Rules.** When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

- A. The primary Coverage Plan pays or provides its benefits as if the secondary Coverage Plan or Coverage Plans did not exist.
- B. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.
- C. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.
- D. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.
  1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent; and primary to the Coverage Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.

2. Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one Coverage Plan is:
  - a. The primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:
    - 1) The parents are married;
    - 2) The parents are not separated (whether or not they ever have been married); or
    - 3) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.

- b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or Coverage Plan years commencing after the Coverage Plan is given notice of the court decree.
    - c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      - 1) The Coverage Plan of the custodial parent;
      - 2) The Coverage Plan of the spouse of the custodial parent;
      - 3) The Coverage Plan of the noncustodial parent; and then
      - 4) The Coverage Plan of the spouse of the noncustodial parent.
3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled D(1).
4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.
5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.
6. If the preceding rules do not determine the primary Coverage Plan, the allowable expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

#### **Section 7.4 Effect on the Benefits of This Coverage Plan.**

- A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this Coverage Plan would have paid had it been the primary Coverage Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this Coverage Plan

to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this Coverage Plan will:

1. Determine its obligation to pay or provide benefits under its contract;
2. Determine whether a benefit reserve has been recorded for the covered person; and
3. Determine whether there are any unpaid allowable expenses during that claims determination period.

If there is a benefit reserve, the secondary Coverage Plan will use the covered person's benefit reserve to pay up to 100% of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

- B. If a covered person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.

**Section 7.5 Right to Receive and Release Needed Information.** Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Coverage Plan and other Coverage Plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Coverage Plan must give the Company any facts it needs to apply those rules and determine benefit payable. If you do not provide the Company the information it needs to apply these rules and determine the benefits payable, your claim for benefits will be denied.

**Section 7.6 Payments Made.** A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, the Company may pay that amount to the organization that made the payment. That amount will then be treated as though it was a benefit paid under this Coverage Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

**Section 7.7 Right of Recovery.** If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one of more of the persons it had paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## **SECTION 8 - RECOVERY PROVISIONS**

**Section 8.1 Refund of Overpayments.** If the Plan Sponsor pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Plan Sponsor if:

- A. All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person, or
- B. All or some of the payment made by the Plan Sponsor exceeded the benefits under the Plan.

The refund equals the amount the Plan Sponsor paid in excess of the amount it should have paid under the Plan.

If the refund is due from another person or organization, the Covered Person agrees to help the Plan Sponsor get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Plan Sponsor may reduce the amount of any future benefits that are payable under the Plan. The Plan Sponsor may also reduce future benefits under any other group benefits plan administered by Company on behalf of the Plan Sponsor. The reductions will equal the amount of the required refund. The Plan Sponsor may have other rights in addition to the right to reduce future benefits.

**Section 8.2 Reimbursement of Benefits Paid.** If the Plan Sponsor pays benefits for expenses incurred on account of a Covered Person, the Subscriber or any other person or organization that was paid must make a refund to the Plan Sponsor if all or some of the expenses were recovered from or paid by a source other than the Plan as a result of claims against a third party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount the Plan Sponsor paid.

If the refund is due from another person or organization, the Covered Person agrees to help the Plan Sponsor get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Plan Sponsor may reduce the amount of any future benefits that are payable under the Plan. The Plan Sponsor may also reduce future benefits under any other group benefits plan administered by the COMPANY on behalf of the Plan Sponsor. The reduction will equal the amount of the required refund. The Plan Sponsor may have other rights in addition to the right to reduce future benefits.

**Section 8.3 Subrogation and Reimbursement.** Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. The Plan Sponsor shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and benefits provided by the Plan Sponsor to any Covered Person from: (i) third parties, including any person alleged to have caused the Covered Person to suffer injuries or damages; (ii) the employer of the Covered Person; or (iii) any person or entity obligated to provide benefits or payments to Covered Persons, including benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as "Third Parties"). The Covered Person agrees to assign to the Plan Sponsor all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits provided by the Plan Sponsor, plus reasonable costs of collection.

The Covered Person shall cooperate with the Plan Sponsor in protecting the Plan Sponsor's legal rights to subrogation and reimbursement, and acknowledges that the Plan Sponsor's rights shall be considered as the first priority claim against Third Parties, to be paid before any other claims by the Covered Person are paid. The Covered Person shall do nothing to prejudice the Plan Sponsor's rights under this provision, either before or after the need for services or benefits under the Plan. The Plan Sponsor may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in the name of the Covered Person. For the reasonable value of services provided under the Plan, the Plan Sponsor may collect, at its option, amounts from the proceeds of any settlement (whether before or after any determination of liability) or judgment that may be recovered by the Covered Person or his or her legal representative, regardless of whether or not the Covered Person has been fully compensated. Any proceeds of settlement or judgment shall be held in trust by the Covered Person for the benefit of the Plan Sponsor under these subrogation provisions and the Plan Sponsor shall be entitled to recover reasonable attorney fees from the Covered Person incurred in collecting proceeds held by the Covered Person. The Covered Person shall not accept any settlement that does not fully compensate or reimburse the Plan Sponsor without the written approval of the Plan Sponsor. The Covered Person agrees to execute and deliver such documents (including a written confirmation of assignment, and consents to release medical records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as may be reasonably requested by Plan Sponsor.

## **SECTION 9 - CONTINUATION OF COVERAGE**

**Section 9.1 Continuation Coverage.** A Covered Person whose Coverage would otherwise end under this Plan may be entitled to elect continuation Coverage in accordance with federal law (under the Consolidated Omnibus Budget Reconciliation Act or "COBRA") and as outlined in Sections 9.2 through 9.5 below.

Continuation Coverage under COBRA shall be available only to Employers which are subject to the provisions of COBRA. Covered Persons should contact the Plan Sponsor to determine if the Plan Sponsor is subject to COBRA.

Continuation Coverage for Covered Persons who selected continuation Coverage under a prior plan which was replaced by Coverage under this Plan shall terminate as scheduled under the prior plan or in accordance with the terminating events set forth in Section 9.5 below, whichever is earlier.

In no event shall the Company be obligated to provide continuation Coverage to a Covered Person if the Plan Sponsor or its designated plan administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the Covered Person in a timely manner of the right to elect continuation Coverage and notifying the Plan Administrator in a timely manner of the Covered Person's election of continuation Coverage.

A Covered Person whose Coverage would otherwise end under the Plan may be entitled to elect continuation Coverage in accordance with federal law, as outlined in Sections 9.2 through 9.5 below.

**Section 9.2 Continuation Coverage Under Federal Law.** In order to be eligible for continuation coverage under federal law, the Covered Person must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a Qualifying Event:

- a. a Subscriber,
- b. a Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born or placed for adoption with a Subscriber during a period of continuation Coverage, or
- c. a Subscriber's former spouse.

**Section 9.3 Qualifying Events for Continuation Coverage Under Federal Law.** If a Qualified Beneficiary's Coverage will ordinarily terminate due to one of the following Qualifying Events, he or she is entitled to continue Coverage. The Qualified Beneficiary is entitled to elect to continue the same Coverage that he or she had on the day before the Qualifying Event.

- A. Termination of the Subscriber from employment with the Enrolling Group (for any reason other than gross misconduct) or reduction of hours; or
- B. Death of the Subscriber; or
- C. Divorce or legal separation of the Subscriber; or
- D. Loss of eligibility by an Enrolled Dependent who is a child; or
- E. Entitlement of the Subscriber to Medicare benefits; or
- F. The Plan Sponsor filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Enrolled Dependents. This is also a Qualifying Event for any retired Subscriber and his or her Enrolled Dependents if there is a substantial elimination of Coverage within one year before or after the date the bankruptcy was filed.

**Section 9.4 Notification Requirements and Election Period for Continuation Coverage Under Federal Law.** The Subscriber or Qualified Beneficiary must notify the Plan Sponsor's designated plan administrator within 60 days of his or her divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Subscriber or Qualified Beneficiary fails to notify the designated Plan Administrator of these events within the 60 day period, the Enrolling Group and its Plan

Administrator are not obligated to provide continuation Coverage to the affected Qualified Beneficiary. A Subscriber who is continuing Coverage under Federal Law must notify the Plan Sponsor's designated plan administrator within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the Qualifying Event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Plan Sponsor's designated plan administrator.

A Qualified Beneficiary whose Coverage was terminated due to a Qualifying Event must pay the initial required contribution amount to the Enrolling Group's designated plan administrator on or before the 45th day after electing continuation Coverage.

**Section 9.5 Terminating Events for Continuation Coverage Under Federal Law.** Continuation under the Plan will end on the earliest of the following dates:

- A. Eighteen months from the date of a Qualifying Event for a Qualified Beneficiary whose Coverage would have otherwise ended due to termination of employment (for reasons other than gross misconduct) or a reduction in hours. A Qualified Beneficiary who is determined to have been disabled at the time during the first 60 days of continuation Coverage may extend the continuation Coverage to a maximum of 29 months from the date of the Qualifying Event described in Section 9.3 A. If the Qualified Beneficiary entitled to the additional 11 months of Coverage has non-disabled family members who are also entitled to continuation Coverage, those non-disabled family members are also entitled to the additional 11 months of continuation Coverage.

A Qualified Beneficiary who is determined to have been disabled under the Social Security Act within the first 60 days of continuation Coverage for qualifying event (A) must provide notice of such disability within 60 days after the determination of the disability, and in no event later than the end of the first 18 months, in order to extend Coverage beyond 18 months. If such notice is provided, the Qualified Beneficiary's Coverage may be extended up to a maximum of 29 months from the date of the Qualifying Event described in Section 9.3 A or until the first month that begins more than 30 days after the date of any final determination that the Qualified Beneficiary is no longer disabled. Each Qualified Beneficiary must provide notice of any final determination that the Qualified Beneficiary is no longer disabled within 30 days of such determination.

- B. Thirty-six months from the date of the Qualifying Event for an Enrolled Dependent whose Coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, loss of eligibility by an Enrolled Dependent who is a child in accordance with Qualifying Events (B), (C) or (D) described in Section 9.3.
- C. For the Enrolled Dependents of a Subscriber who was entitled to Medicare prior to a Qualifying Event that was due to either the termination of employment or work hours being reduced, 18 months from the date of the Qualifying Event, or, if later, 36 months from the date of the Subscriber's Medicare entitlement.
- D. The date Coverage terminates under the Plan for failure to make timely payment of the required contribution amounts.
- E. The date, after electing continuation Coverage, that coverage is obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any preexisting condition of the Qualified Beneficiary, continuation Coverage shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services which are subject to the preexisting condition limitation or exclusion.
- F. The date, after electing continuation coverage, that the Qualified Beneficiary becomes entitled to Medicare, except that this shall not apply in the event the Qualified Beneficiary's Coverage was terminated because the Plan Sponsor filed for bankruptcy, in accordance with Qualifying Event (F) described in Section 9.3.
- G. The date the entire Plan ends.

H. The date Coverage would otherwise terminate under the Plan.

If a Qualified Beneficiary is entitled to 18 months of continuation Coverage and a second Qualifying Event occurs during that time, the continuation Coverage of a Qualified Beneficiary who is an Enrolled Dependent may be extended up to a maximum of 36 months from the Qualifying Event described in Section 9.3 A. If a Qualified Beneficiary is entitled to continuation Coverage because the Plan Sponsor filed for bankruptcy, in accordance with Qualifying Event (F) described in Section 9.3 and the retired Subscriber dies during the continuation period, the Enrolled Dependents shall be entitled to continue Coverage for 36 months from the date of death. Terminating events (B) through (H) described in this Section 9.5 shall apply during the extended continuation period.

Continuation Coverage for Qualified Beneficiaries whose continuation Coverage terminates because the Subscriber becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Plan Sponsor's designated plan administrator for information regarding the continuation period.

## **SECTION 10 - PROCEDURES FOR OBTAINING BENEFITS**

**Section 10.1 Dental Services.** You are eligible for Coverage for Dental Services listed in the Covered Services Section of this SPD if such Dental Services are Necessary and are provided by or under the direction of a Dentist or other provider. All Coverage is subject to the terms, conditions, exclusions and limitations of the Plan.

### **Network Providers**

The Company has arranged with certain dental care providers to participate in a network. These Network Providers have agreed to discount their charges for Covered services and supplies.

If Network Providers are used, the amount of Covered expenses for which a Covered Person is responsible will generally be less than the amount owed if Non-Network Providers had been used. The Copayment level (the percentage of covered expenses for which a Covered Person is responsible) remains the same whether or not Network Providers are used. However, because the total charges for covered expenses may be less when Network Providers are used, the portion that the covered person owes will generally be less.

Covered Persons are issued an identification card (ID card) showing they are eligible for Network discounts. A Covered Person must show this ID card every time dental care services are given. This is how the Provider knows that the patient is Covered under a Network plan. Otherwise, the person could be billed for the Provider's normal charge.

A Directory of Network Providers will be made available. A Covered Person can also call Customer Service to determine which Providers participate in the Network. The telephone number for Customer Services is on the ID card.

Network Providers are responsible for submitting a request for payment directly to the Company, however, a Covered Person is responsible for any Copayment at the time of service. If a Network Provider bills a Covered Person, Customer Services should be called. A Covered Person does not need to submit claims for Network Provider services or supplies.

**Section 10.2 Pre-Determination of Benefits.** If the charge for a Dental Service is expected to exceed \$200 or if a dental exam reveals the need for fixed bridgework, you should notify the Company of such treatment before treatment begins. You must send the notice to the Company within 20 days of the exam. If requested the Dentist must provide the Company with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Company, on behalf of the Plan Administrator, will decide if the proposed treatment is Covered under the Plan and estimate the amount of payment. The estimate of benefits payable will be sent to the Dentist and will be subject to all terms, conditions and provisions of the Plan. If a treatment plan is not submitted, the Covered Person will be responsible for payment of any dental treatment not approved by the Company.

Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

Pre-determination of benefits is not an agreement to pay for expenses. This procedure lets the Covered Person know in advance approximately what portion of the expenses will be considered for payment. No benefits will be paid for a Dental Service that is not begun within 90 days after the treatment plan notice is sent to the Company.

## SECTION 11 - COVERED DENTAL SERVICES

Covered Dental Services are subject to satisfaction of the Annual Deductible, applicable waiting periods and Copayments as described in the Schedule of Benefits.

- A. Necessary (refer to the Section entitled Definitions);
- B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;
- C. The least costly, clinically accepted treatment; and
- D. Not excluded as described in the Section entitled General Exclusions.

This Schedule of Covered Dental Services (1) describes the Covered Dental Services and any applicable limitation to each service, (2) outlines the Copayments that you are required to pay for each Covered Dental Service and (3) describes the Annual Deductible and any Annual Maximum Benefits that may apply.

**Network Benefits** are subject to the satisfaction of the appropriate waiting periods, the Annual Deductible and the payment of any Copayments listed below. Covered Dental Services must be provided by or directed by a Network Dentist.

When Network Copayments are charged as a percentage of Eligible Expenses, the amount you pay for Dental Services from Network providers is determined as a percentage of the negotiated contract fee between the Plan Administrator, on behalf of the Plan Administrator, and the provider rather than as a percentage of the provider's billed charge. The Plan Administrator's negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge a Covered Person or the Plan Sponsor for any service or supply that is not Necessary as determined by the Plan Administrator. If a Covered Person agrees to receive a service or supply that is not Necessary the Network provider may charge the Covered Person. However, these charges will not be considered Covered Dental Services and will not be payable by the Plan.

**Non-Network Benefits** are subject to the satisfaction of the appropriate Waiting Period, the Annual Deductible and payment of Copayments listed below. When Copayments are charged as a percentage of the Usual and Customary fees, the amount you pay for Dental Services from Non-Network providers is determined as a percentage of the Usual and Customary fee **plus** the amount by which the Non-Network provider's billed charge exceeds the Usual and Customary fee.

For Network Benefits, the **Annual Deductible** is \$50 per Covered Person per calendar year. The **Annual Deductible** applies to Non-Preventive Dental Services. For Non-Network Benefits, the **Annual Deductible** is \$50 per Covered Person per calendar year. The **Annual Deductible** applies to Non-Preventive Dental Services.

### Section 11.1 PREVENTIVE DENTAL SERVICES

SECTION - BENEFIT DESCRIPTION	LIMITATIONS
Bacteriologic Cultures	
Bite-Wing Radiographs	Limited to 2 series of films per calendar year.
Complete Series or Panorex Radiographs	Limited to one time per 36 months.
Dental Prophylaxis	Limited to two times per calendar year.
Diagnostic Casts	Limited to one time per 24 months.
Extraoral Radiographs	Limited to 2 films per calendar year.

SECTION - BENEFIT DESCRIPTION	LIMITATIONS
Fluoride Treatments	Limited to Covered Persons under the age of 19 years, and limited to 1 time per 12 month period. Treatment should be done in conjunction with dental prophylaxis.
Individual Periapical Radiographs	
Occlusal Radiographs	
Oral Examinations	Covered as a separate benefit only if no other service was done during the visit other than x-rays. Limited to 2 times per calendar year.
Sealants	Limited to Covered Persons under the age of 19 years , once per first or second permanent molar every 5 calendar years.

**Section 11.2 BASIC DENTAL SERVICES**

<b>SECTION - BENEFIT DESCRIPTION</b>	<b>LIMITATIONS</b>
Minor Restorative Services	
Amalgam Restorations	Multiple restorations on one surface will be treated as a single filling. One restoration allowed per surface every 3 calendar years.
Composite Resin Restorations	One restoration allowed per surface every 3 calendar years.
Pin Retention	Limited to 2 pins per tooth; not covered in addition to Cast Restoration.
Space Maintainers	Limited to Covered Persons under the age of 16 years, once per lifetime. Benefit includes all adjustment within 6 months of installation.
Stainless Steel Crowns	Limited to once every 5 calendar years. Covered only when a filling cannot restore the tooth.
Endodontics	
Apexification Apicoectomy and Retrograde filling Hemisection Root Canal Therapy Root Resection Therapeutic Pulpotomy	
Periodontics	
Crown Lengthening* Gingivectomy* Osseous Graft* Osseous Surgery*	
Periodontal Maintenance	Limited to 2 times within the first 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.
Provisional Splinting	
Scaling and Root Planning	Limited to 1 time per quadrant per 24 months.
Soft Tissue Surgery*	
Oral Surgery Alveoloplasty Biopsy Frenectomy Incision and Drainage Removal of a Benign Cyst Removal of Exostosis Root Recovery Root Removal Simple Extraction Surgical Extraction of Erupted Teeth and Roots Surgical Extraction of Impacted Teeth	

<b>SECTION - BENEFIT DESCRIPTION</b>	<b>LIMITATIONS</b>
Adjunctive Services	
Anelgesia Desensitizing Medicament General Anesthesia Intravenous Sedation and Analgesia Occlusal Adjustment	
Occlusal Guards	Limited to one guard every 5 calendar years.
Palliative Treatment	Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit.
Re-cement Bridges	Once every 6 months per restoration.
Re-cement Crowns	Once every 6 months per restoration.
Re-cement Inlays	Once every 6 months per restoration.
Relining Dentures	Limited to relining done more than 6 months after the initial insertions. Limited to 1 time per calendar year.
Repairs to Full Dentures, Partial Dentures, Bridges	Limited to repairs or adjustments done after 12 months after the initial insertion.
Only one of the above [*] procedures is covered per quadrant or site per 36 months.	

**Section 11.3 MAJOR DENTAL SERVICES**

<b>SECTION - BENEFIT DESCRIPTION</b>	<b>LIMITATIONS</b>
Crowns	Limited to one time per 5 calendar years. Covered only when a filling cannot restore the tooth.
Fixed Bridges	Once every 5 calendar years.
Full Dentures	No additional allowances for over-dentures or customized dentures. Once every 5 calendar years.
Gold Inlays and Onlays	Limited to one time per 5 calendar years. Covered only when silver fillings cannot restore the tooth.
Partial Dentures	No additional allowances for precision or semi precision attachments. Once every 5 calendar years.
Porcelain Onlays	
Post and Cores	Covered only for teeth that have had root canal therapy.
Sedative Fillings	Covered as a separate benefit only if no other service, other than X-Rays and exam, were done during the visit.
<b>ORTHODONTIC SERVICES (Children Only)</b>	
Diagnose or correct misalignment of the teeth or bite including Phase I and Phase II	Preauthorization required.

## SECTION 12 - GENERAL EXCLUSIONS

**Section 12.1 Exclusions.** Except as may be specifically provided in the Section entitled Covered Services or through an Amendment to the SPD, the following are not covered:

- A. Dental Services that are not Necessary.
- B. Hospitalization or other facility charges.
- C. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance).
- D. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
- E. Any dental procedure not directly associated with dental disease.
- F. Any procedure not performed in a dental setting.
- G. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- H. Placement of dental implants, implant-supported abutments and prostheses. This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.
- I. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- J. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or.
- K. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- L. Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal. Treatment of congenital malformations of hard or soft tissue, including excision.
- M. Replacement of complete or partial dentures, fixed bridgework, or crowns previously submitted for payment under the Plan within sixty (60) months of initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
- N. Replacement of complete or partial dentures, crowns, or fixed bridgework if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
- O. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
- P. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
- Q. Expenses for dental procedures with a date of service prior to the Covered Person's eligibility with the Plan.

- R. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- S. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- T. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- U. Full mouth radiograph series in excess of once every 36 months. Panoramic radiographs in excess of once every 36 months, except when taken for diagnosis of third molars, cysts, or neoplasms.
- V. Denture relines for complete or partial conventional dentures for the 6 month period following the insertion of a prosthesis. Tissue conditioning and soft and hard relines for immediate full and partial dentures for the 6 months. After the six month waiting period, relines are covered not more than once every 12 months.
- W. Root planing and scaling (ADA Code 4341) in excess of once every 24 months per quadrant.
- X. Hard tissue periodontal surgery and soft tissue periodontal surgery per surgical area in excess of once in any 36 month period. This includes gingivectomy, gingivoplasty, gingival curettage (with or without a flap procedure), osseous surgery, pedicle grafts, and free soft tissue grafts.
- Y. Osseous grafts, with or without resorbable or non-resorbable GTR membrane placement in excess of once every 36 months per quadrant or surgical site.
- Z. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to Plan coverage unless the patient has been eligible under the Plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the Plan is responsible only for the procedures associated with the addition.
- AA. Replacement of missing natural teeth lost prior to the onset of Plan coverage until the patient has been eligible for 12 continuous months.
- BB. Billing for incision and drainage (ADA Code 7510) if the involved abscessed tooth is removed on the same date of service.
- CC. Full mouth debridement (ADA Code 4355) in excess of once every 36 months.
- DD. Occlusal guards except if prescribed to control of habitual grinding, including those specifically used as safety items or to affect performance primarily in sports-related activities.
- EE. Placement of fixed bridgework solely for the purpose of achieving periodontal stability.
- FF. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
- GG. Dental Services otherwise Covered under the Plan, but rendered after the date individual Coverage under the Plan terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Plan terminates, except those conditions Covered under the Extension of Benefits in Section 3.
- HH. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
- II. General Anesthesia, except if required for patients under 6 years of age or patients with behavioral problems or physical disabilities.

- JJ. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
- KK. Dental Services provided in a foreign country, unless required as an Emergency.

## SECTION 13 - SCHEDULE OF BENEFITS

This Schedule of Benefits (1) outlines the Copayments and Deductibles that you are required to pay for Dental Services and (2) describes any maximum benefit that may apply. Covered Dental Services are described more completely in the Section entitled Covered Dental Services. The section number next to each Covered Dental Service is the corresponding section where you will find detailed requirements and conditions within the Section entitled Covered Dental Services.

Benefits are subject to satisfaction of the applicable waiting periods, the Annual Deductible and payment of Copayments listed under the "Copayment" column.

**\*Also, you must pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expenses, or charges over Usual, Reasonable & Customary.**

SECTION - BENEFIT DESCRIPTION	COPAYMENT After the Annual Deductible
11.1 Preventive Dental Services	100% of Eligible Expenses.* Annual Deductible does not apply.
11.2 Basic Dental Services	
Minor Restorative	80% of Eligible Expenses.*
Endodontics	80% of Eligible Expenses.*
Periodontics	80% of Eligible Expenses.*
Oral Surgery	80% of Eligible Expenses.*
Adjunctive Services	80% of Eligible Expenses.*
11.3 Major Dental Services	50% of Eligible Expenses.*
Orthodontics Services	50% of Eligible Expenses
Annual Deductible	\$50 per Covered Person per calendar year not to exceed \$150 for all Covered Persons in a family.
Annual Maximum Benefit	\$2,000 per Covered Person.
Orthodontic Lifetime Maximum Benefit	\$2,000 per Covered Person

## **ORTHODONTIC SERVICES AMENDMENT**

The Plan is modified by the attachment of this Amendment to provide Coverage for Orthodontic Services.

### **ORTHODONTIC SERVICES**

Services or supplies furnished by a Dentist to a Covered Dependent under age 19 in order to diagnose or correct misalignment of the teeth or the bite.

Not included is the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion.

Pre-Determination of Benefits - If a dental exam reveals the need for orthodontia, you should notify the Company of such treatment before treatment begins. You must send the notice to the Company within 20 days of the exam. If requested the Dentist must provide the Company with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Company, on behalf of the Plan Administrator, will decide if the proposed treatment is Covered under the Plan and estimate the amount of payment. The estimate of benefits payable will be sent to the Dentist and will be subject to all terms, conditions and provisions of the Plan. If a treatment plan is not submitted, the Covered Person will be responsible for payment of any dental treatment not approved by the Company. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

Pre-determination of benefits is not an agreement to pay for expenses. This procedure lets the Covered Person know in advance approximately what portion of the expenses will be considered for payment. No benefits will be paid for an Orthodontic Service that is not begun within 90 days after the treatment plan notice is sent to the Company.

**COPAYMENT:** 50% of Eligible Expenses.

### **ORTHODONTIC MAXIMUM:**

Not more than \$2,000 will be payable for Covered Orthodontia Services in a Covered Dependent's under age 19 lifetime.

### **WAITING PERIOD:**

**Dental Option 1: No Orthodontic Waiting Period** - Any employee currently covered under the self-funded Plan with the City of Plano for dental benefits will have no waiting period for him/herself or Covered dependents.

**Dental Option 2: 12 month Orthodontic Waiting Period** - Any employee (who is a late enrollee) and is not currently covered under the City of Plano's self-funded Plan will have a 12 month waiting period for Orthodontia.

**NOTE:** The Extended Coverage provision in the SPD does not apply to Orthodontic Services Covered through this Amendment. All other provisions that appear in the SPD apply to Orthodontic Services.





