EMPLOYEE BENEFIT BOOKLET

Dental PPO

FOR

Fraternal Order of Police Fort Lauderdale Lodge 31 Insurance Trust

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INTRODUCTION

Coverage is subject to the terms, conditions, exclusions, and limitations of the Plan. As a Employee Benefit Booklet ("BOOKLET"), this document describes the provisions of Coverage under the Plan but does not constitute the Plan. You may examine the entire Plan at the office of the Plan Sponsor during regular business hours.

For Dental Services rendered after the effective date of the Plan, this BOOKLET replaces and supersedes any BOOKLET, which may have been previously issued to you by the Plan Sponsor. Any subsequent BOOKLETs issued to you by the Plan Sponsor will in turn supersede this BOOKLET.

How To Use This BOOKLET

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

Your BOOKLET 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 BOOKLET may have been changed.

Many words used in this BOOKLET 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 BOOKLET.

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

Network and Non-Network Benefits

This BOOKLET describes both benefit levels available under the Plan.

Network Benefits - These benefits apply when you choose to obtain Dental Services from a Network Provider. The Section entitled Procedures for Obtaining Benefits describes the procedures for obtaining Covered Dental Services as Network Benefits. Unless otherwise noted in the Schedule of Covered Dental Services, Network Benefits generally provide Coverage at a higher level than Non-Network Benefits. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network provider an amount for a Covered Dental Service in excess of the contracted fee.

Non-Network Benefits - These benefits apply when you decide to obtain Dental Services from Non-Network providers. The Section entitled Procedures for Obtaining Benefits describes the procedures for obtaining Covered Dental Services as Non-Network Benefits. Unless otherwise noted in the Schedule of Covered Dental Services, Non-Network Benefits are subject to an Annual Deductible and generally require you to pay more than Network Benefits. Non-Network Benefits are determined based on the Usual and Customary fee for similarly situated Network providers for each Covered Dental Service. The actual charge made by a Non-Network provider for a Covered Dental Service may exceed the Usual and Customary fee. As a result, you may be required to pay a Non-Network Provider an amount for a Covered Dental Service in excess of the Usual and Customary fee. In addition, when you obtain Covered Dental Services from Non-Network providers, you must file a claim with the TPA to be reimbursed for Eligible Expenses.

The information in the Section entitled Definitions through the Section entitled Recovery Provisions applies to both levels of Coverage. The Section entitled Procedures for Obtaining Benefits and the Section entitled Covered Dental Services explain the procedures you must follow to obtain Coverage for Network Benefits and Non-Network Benefits respectively. The Covered Dental Services Section describes which Dental Services are Covered. Unless otherwise specified, the exclusions and limitations that appear in the

Section entitled General Exclusions apply to both levels of benefits. The Schedule of Covered Dental Services describes what Copayments are required, if any, and to what extent any limitations apply.

Dental Services Covered Under the Plan

In order for Dental Services to be Covered as Network Benefits, you must obtain all Dental Services directly from or through a Network provider.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling the TPA. If necessary, the TPA can provide assistance in referring you to Network providers. If you use a provider that is not a participating provider, you will be required to pay the bill for the services you received.

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 or amendments to the Plan.

The Plan Sponsor may, in certain circumstances for purposes of overall cost savings or efficiency and in its sole discretion, provide Coverage for services, which would otherwise not be Covered. The fact that the Plan Sponsor does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

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.

Important Note About Services

The TPA does not provide Dental Services or practice dentistry. Rather, the TPA arranges for providers of Dental Services to participate in a Network. Network providers are independent practitioners and are not employees of the TPA. The TPA, therefore, makes payment to Network providers through various types of contractual arrangements. These arrangements may include financial incentives to promote the delivery of dental care in a cost efficient and effective manner. Such financial incentives are not intended to impact your access to Necessary Dental Services.

The payment methods used to pay any specific Network provider vary. The method may also change at the time providers renew their contracts with the TPA. If you have questions about whether there are any financial incentives in your Network provider's contract with the TPA, please contact the TPA at the telephone number on your ID card. The TPA can advise you whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms, including rates of payment, are confidential and cannot be disclosed.

The Dentist-patient relationship is between you and your Dentist. This means that:

- You are responsible for choosing your own Dentist.
- You must decide if any dentist treating you is right for you. This includes Network providers who you choose or providers to whom you have been referred.
- You must decide with your Dentist what care you should receive.
- Your Dentist is solely responsible for the quality of the care you receive.

The TPA, on behalf of the Plan Sponsor, makes decisions about benefit plan Coverage. These decisions are administrative decisions and are for payment purposes only. The TPA is not liable for any act or omission of a provider of Dental Services.

Important Information Regarding Medicare

Coverage under the Plan is not intended to supplement any coverage provided by Medicare, but in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled for Coverage under the Plan. If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare, you must enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll, and if the Plan Sponsor is the secondary payer as described in the Section of this BOOKLET entitled Coordination of Benefits, the Plan Sponsor will pay benefits under the Plan as if you were covered under both Medicare Part A and Part B and you will incur a larger out of pocket cost for Dental Services.

If, in addition to being enrolled for Coverage under the Plan, you are enrolled in a Medicare+Choice (Medicare Part C) plan, you must follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan Sponsor is the secondary payer, the Plan will pay any benefits available to you under the Plan as if you had followed all rules of the Medicare+Choice plan. If this Plan is the secondary plan and you don't follow the rules of the Medicare+Choice plan, you will incur a larger out of pocket cost for Dental Services.

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 BOOKLET 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 the TPA at the telephone number stated on your ID card.

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SECTION 1 - DEFINITIONS

This Section defines the terms used throughout this BOOKLET 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 plan year for a Covered Person under the Plan or any Plan covering the Plan Sponsor that replaces the Plan. The Annual Maximum Benefit is stated in the Schedule of Covered Dental Services.

"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 for Plan Benefits 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 BOOKLET 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 TPA on behalf of 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" - (1) the Subscriber's legal spouse or (2) an unmarried dependent child of the Subscriber or the Subscriber's spouse (including a natural child, stepchild, a legally adopted child, or a child placed for adoption). The term "child" also includes a grandchild of either the Subscriber or the Subscriber's spouse. The principal place of residence of the legal spouse or dependent child must be with the Subscriber unless the Plan Administrator approves other arrangements or except as ordered and described below. The definition of "Dependent" is subject to the following conditions and limitations:

A. The term "Dependent" shall not include any unmarried dependent child 19 years of age or older, except as stated in the next paragraph;

B. The term "Dependent" shall include an unmarried dependent child who is 19 years of age or older, but less than 25 years of age if evidence satisfactory to the Plan Administrator of the following conditions is furnished upon request:

   1. the child is not regularly employed on a full-time basis; and

2. the child is a Full-time Student; and

3. the child is primarily dependent upon the Subscriber for support and maintenance.

The Subscriber agrees to reimburse the Plan Sponsor for any Dental Services provided to the child at a time when the child did not satisfy these conditions.

The term "Dependent" also includes a child for whom dental care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. The Plan Administrator is responsible for determining if an order meets the criteria of a 'Qualified Medical Child Support Order'.

The term "Dependent" does not include anyone who is also enrolled as a Subscriber, nor can anyone be a "Dependent" of more than one Subscriber.

"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 TPA'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 and (3) who has medical coverage through the Plan Sponsor.

"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 TPA, 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.

"Full-time Student" - a person who is enrolled in and attending, full-time, a recognized course of study or training at:

A. An accredited high school;

B. An accredited college or university; or

C. A licensed vocational school, technical school, beautician school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. A person ceases to be a Full-time Student at the end of the calendar year during which the person graduates or otherwise ceases to be enrolled and in attendance at the institution on a full-time basis.

A person continues to be a Full-time Student during periods of regular vacation established by the institution. If the person does not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end on the last day of the calendar year in which the person was enrolled and in attendance at the institution on a full-time basis.

"Medicare" - Parts A, B, and C of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

"Necessary" - dental care services and supplies which are determined by the TPA, 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 TPA; 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 BOOKLET. The definition of Necessary used in this BOOKLET relates only to Coverage and differs from the way in which a Dentist engaged in the practice of dentistry may define necessary.

"Network" - a group of Dentists who are subject to a participation agreement in effect with the TPA, directly or through another entity, to provide Dental Services to Covered Persons. The participation status of providers will change from time to time.

"Network Benefits" - benefits available for Covered Dental Services when provided by a Dentist who is a Network provider.

"Non-Network Benefits" - coverage available for Dental Services obtained from Non-Network providers.

"Open Enrollment Period" - after the Initial Eligibility Period, a period of time determined by the Plan Sponsor 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" - Fraternal Order of Police Fort Lauderdale Lodge 31 Insurance Trust

"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 TPA 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 TPA's reimbursement policy guidelines. The TPA's reimbursement policy guidelines are developed by the TPA, 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 TPA.

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 as 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 or be covered as an eligible Dependent of the other, but not both. 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 the later of June 1, 2007 or the date of hire. 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 of hire. Coverage is effective only if the Plan Sponsor receives any required contribution 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, or marriage 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. However, with respect to newborn children, adopted children or children placed for adoption, such enrollment and payment of any required contribution is necessary only to continue coverage beyond the 31 days following the event that makes the child eligible. In the absence of enrollment within 31 days of the event that makes such Dependent child eligible, coverage will be provided for the first 31 days for such Dependent child.

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 of 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 provided under 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.

D. The date specified by the Plan Administrator that all Coverage will terminate due to fraud or misrepresentation or because the Subscriber knowingly provided the Plan Administrator with false material information, including, but not limited to, false, material information relating to residence information relating to another person's eligibility for Coverage or status as a Dependent. The Plan Sponsor has the right to rescind Coverage back to the effective date.

E. The date specified by the Plan Administrator that all Coverage will terminate because the Subscriber permitted the use of his or her ID card by any unauthorized person or used another person’s card.

F. The date specified by the Plan Administrator that Coverage will terminate due to material violation of the terms of the Plan.

G. The date specified by the Plan Administrator that your Coverage will terminate because you failed to pay a required Copayment for Dental Services rendered.

H. The date specified by the Plan Administrator that your Coverage will terminate because you have committed acts of physical or verbal abuse which pose a threat to the Plan Sponsor, TPA, staff, a provider, or other Covered Persons.

Section 3.2 Extended Coverage. A 90-day 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 90-day period or (b) the date the Covered Person becomes covered under a succeeding policy 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 3.3 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 TPA office, on a form provided by or satisfactory to the TPA. 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 TPA within one year of the date of service shall cancel or reduce Coverage for the Dental Service.

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 TPA at the telephone number stated on your ID Card and a claim form will be sent to you. 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 TPA 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 one year after the date of service.

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

A. the provider notifies the TPA 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 three 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 the TPA within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The TPA 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, the TPA 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 the TPA within 15 days of receipt of the claim. If you filed a pre-service claim improperly, the TPA 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, the TPA 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, the TPA 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 the TPA 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, the TPA 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, the TPA 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. the TPA'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, 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. The TPA 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 will receive notice of the benefit determination in writing or electronically within 72 hours after the TPA receives all necessary information, taking into account the seriousness of your condition.

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 5.1, 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 the TPA.

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 The TPA 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 the TPA 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. The TPA (first level appeals) and the Plan Administrator (second level appeals) 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 the TPA 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 the Plan Administrator 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 the Plan Administrator 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 the Plan Administrator 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 the TPA, you have the right to request a second level appeal from the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 60 days from receipt of first level appeal decision. The Plan Administrator has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

Please note that the Plan Administrator'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 the TPA as soon as possible. The TPA 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 the TPA the exclusive right to interpret and administer the provisions of the Plan. The TPA'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 TPA 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 health and 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 providers, 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 plan 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 claim 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 claim 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.

C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

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 Plan 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 Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Coverage Plan must give the Plan any facts it needs to apply those rules and determine benefit payable. If you do not provide the Plan 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 Plan 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 Plan 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 or 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 the TPA 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 TPA 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 - 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 BOOKLET 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 Benefits

Dental Services must be provided by a Network Dentist in order to be considered Network Benefits.

Enrolling for Coverage under the Plan does not guarantee Dental Services by a particular Network provider on the list of providers. This list of Network providers is subject to change. When a provider on the list no longer has a contract with the TPA, on behalf of the Plan Administrator, you must choose among remaining Network providers. You are responsible for verifying the participation status of the Dentist or other provider prior to receiving such Dental Services. You must show your ID card every time you request Dental Services.

If you fail to verify participation status or to show your ID card, and the failure results in non-compliance with required Plan procedures, Coverage of Network Benefits may be denied.

Coverage for Dental Services is subject to payment of contributions required for Coverage under the Plan, satisfaction of the Annual Deductible and payment of the Copayment specified for any service and payment of the percentage of Eligible Expenses shown in the Schedule of Covered Dental Services.

Non-Network Benefits

Non-Network Benefits apply when you obtain Dental Services from Non-Network providers. Non-Network Benefits are available for certain Dental Services described in the Section entitled Covered Dental Services.

Before you are eligible for Coverage of Dental Services obtained from Non-Network providers, you must meet the requirements for payment of the Annual Deductible specified in the Schedule of Covered Dental Services. Non-Network providers may request that you pay all charges when services are rendered. You must file a claim with the TPA for reimbursement of Eligible Expenses.

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 TPA of such treatment before treatment begins. You must send the notice to the TPA within 20 days of the exam. If requested the Dentist must provide the TPA with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The TPA, 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 TPA. 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 TPA.

SECTION 10 - COVERED DENTAL SERVICES

Dental Services described in this section are Covered when such services are:

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 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 TPA, on behalf of the Plan Administrator, and the provider rather than as a percentage of the provider's billed charge. The TPA'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 TPA. 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 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, not to exceed $150 for all Covered Persons in a family. The **Annual Deductible** applies to Non-Preventive Dental Services. For Non-Network Benefits, the **Annual Deductible** is $50 per Covered Person per calendar year not to exceed $150 for all Covered Persons in a family. The **Annual Deductible** applies to Non-Preventive Dental Services.

Annual Maximum Benefit is $1,500 per Covered Person for Network Benefits and $1,000 per Covered Person for Non-Network Benefits. The sum of all Network and Non-Network benefits will not exceed an Annual Maximum Benefit of $1,500 per Covered Person.

Section 10.1 PREVENTIVE DENTAL SERVICES

BENEFIT DESCRIPTION & LIMITATION	**NETWORK COPAYMENT** The Copayment is shown as a percentage of Eligible Expenses.	**NON-NETWORK COPAYMENT** The Copayment is shown as a percentage of Eligible Expenses. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Bacteriologic Cultures.	0%	20%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses.	NON-NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Bite-Wing Radiographs. Limited to 1 series of films per calendar year.	0%	20%
Complete Series or Panorex Radiographs. Limited to 1 time per 36 consecutive months.	0%	20%
Dental Prophylaxis. Limited to 1 time per 6 consecutive months.	0%	20%
Diagnostic Casts. Limited to 1 time per 24 consecutive months.	0%	20%
Extraoral Radiographs. Limited to 2 films per calendar year.	0%	20%
Fluoride Treatments. Limited to Covered Persons under the age of 16 years, and limited to 1 time per 6 consecutive months. Treatment should be done in conjunction with dental prophylaxis.	0%	20%
Individual Periapical Radiographs.	0%	20%
Occlusal Radiographs.	0%	20%
Oral Examinations. Limited to 1 time per 6 consecutive months.	0%	20%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses.	NON-NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Sealants. Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	0%	20%

Section 10.2 NON-PREVENTIVE DENTAL SERVICES

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied.	NON-NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Minor Restorative Services		
Amalgam Restorations. Multiple restorations on one surface will be treated as a single filling.	20%	40%
Composite Resin Restorations. Multiple restorations on one surface will be treated as a single filling. Covered on anterior teeth only.	20%	40%
Space Maintainers		
Space Maintainers. Limited to Covered Persons under the age of 16 years, once per lifetime. Benefit includes all adjustments within 6 months of installation.	20%	40%
Endodontics		
Apexification.	20%	40%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT **The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied.**	NON-NETWORK COPAYMENT **The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.**
Apicoectomy and Retrograde filling.	20%	40%
Hemisection.	20%	40%
Root Canal Therapy.	20%	40%
Root Resection.	20%	40%
Therapeutic Pulpotomy.	20%	40%
Periodontics		
Crown Lengthening.**	20%	40%
Gingivectomy.**	20%	40%
Osseous Graft.**	20%	40%
Osseous Surgery.**	20%	40%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied.	NON-NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Periodontal Maintenance. Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy within the prior 24 months, exclusive of gross debridement.	20%	40%
Provisional Splinting.	20%	40%
Scaling and Root Planing. Limited to 1 time per quadrant per 24 consecutive months.	20%	40%
Soft Tissue Surgery.**	20%	40%
Only one of the above [**] procedures is covered per quadrant or site per 36 consecutive months		
Oral Surgery		
Alveoloplasty.	20%	40%
Biopsy.	20%	40%
Frenectomy.	20%	40%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied.	NON-NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Incision and Drainage.	20%	40%
Removal of a Benign Cyst.	20%	40%
Root Recovery.	20%	40%
Root Removal.	20%	40%
Simple Extraction.	20%	40%
Surgical Extraction of Erupted Teeth and Roots.	20%	40%
Surgical Extraction of Impacted Teeth.	20%	40%
Adjunctive Services		
Analgesia.	20%	40%
Desensitizing Medicament.	20%	40%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT **The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied.**	NON-NETWORK COPAYMENT **The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.**
General Anesthesia. Covered only when clinically necessary.	20%	40%
Intravenous Sedation and Analgesia.	20%	40%
Occlusal Adjustment.	20%	40%
Occlusal Guards. Limited to 1 guard every 5 calendar years and only covered if prescribed to control habitual grinding.	20%	40%
Palliative Treatment. Covered as a separate benefit only if no other services, other than exam and radiographs, were done on the same tooth during the visit.	20%	40%
Major Restorative Services		
Crowns. Limited to 1 time per tooth every 5 calendar years. Covered only when a filling cannot restore the tooth.	40%	60%
Gold Inlays and Onlays. Limited to 1 time per tooth every 5 calendar years. Covered only when silver fillings cannot restore the tooth.	40%	60%
Pin Retention. Limited to 2 pins per tooth; not covered in addition to Cast Restoration.	40%	60%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied.	NON-NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Porcelain Onlays. Limited to 1 time per tooth every 5 calendar years. Covered only when silver fillings cannot restore the tooth.	40%	60%
Post and Cores. Covered only for teeth that have had root canal therapy.	40%	60%
Re-cement Crowns. Limited to those done more than 12 months after the initial insertion.	40%	60%
Re-cement Inlays. Limited to those done more than 12 months after the initial insertion.	40%	60%
Sedative Fillings. Covered as a separate benefit only if no other service, other than X-Rays and exam, were done on the same tooth during the visit.	40%	60%
Stainless Steel Crowns		
Stainless Steel Crowns.	40%	60%
Fixed Prosthetics		
Fixed Partial Dentures (Bridges). Limited to 1 time per tooth per 60 consecutive months. Covered only when silver fillings cannot restore the tooth.	40%	60%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied.	NON-NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses after Annual Deductible is Satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Re-cement Bridges. Limited to those done more than 12 months after the initial insertion.	40%	60%
Removable Prosthetics		
Full Dentures. Limited to 1 time per 60 consecutive months. Covered only when silver fillings cannot restore the tooth. No additional allowances for over-dentures or customized dentures.	40%	60%
Removable Partial Dentures. Limited to 1 time per 60 consecutive months. Covered only when silver fillings cannot restore the tooth. No additional allowances for precision or semi precision attachments.	40%	60%
Relining Dentures. Limited to relining done more than 6 months after the initial insertions. Limited to 1 time per 12 consecutive months.	40%	60%
Repairs and adjustments to Full Dentures or Partial Fixed or Removable Dentures. Limited to those done more than 12 months after initial insertion.	40%	60%

SECTION 11 - GENERAL EXCLUSIONS

Section 11.1 Exclusions. Except as may be specifically provided in the Section entitled Covered Services or through an Amendment to the BOOKLET, 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 Workers' 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 Medicare.

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 dentures, fixed and removable partial dentures or crowns previously submitted for payment under the Plan within 60 months of initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

N. Replacement of complete dentures, fixed and removable partial dentures or crowns 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 begun 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 consecutive months. Panoramic radiographs in excess of once every 36 consecutive 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 6-month waiting period, relines are covered not more than once every 12 consecutive months.

W. Root planing and scaling (ADA Code 4341) in excess of once every 24 consecutive months per quadrant.

X. Hard tissue periodontal surgery and soft tissue periodontal surgery per surgical area in excess of once in any consecutive 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 consecutive months per quadrant or surgical site.

Z. Billing for incision and drainage (ADA Code 7510) if the involved abscessed tooth is removed on the same date of service.

AA. Full mouth debridement (ADA Code 4355) in excess of once every 36 consecutive months.

BB. 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.

CC. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

DD. 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.

EE. Dental Services provided in a foreign country, unless required as an Emergency.

FF. 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.

GG. Acupuncture, acupressure and other forms of alternative treatment, whether or not used as anesthesia.

HH. General Anesthesia, except if clinically necessary.

II. In the event that a Non-Network provider routinely waives Copayments and/or the Annual Deductible for a particular Dental Service, the Dental Service for which the Copayments and/or Annual Deductible are waived is not Covered.

ORTHODONTIC SERVICES RIDER

The BOOKLET is modified by the attachment of this Rider to provide Coverage for Orthodontic Services.

ORTHODONTIC SERVICES

Services or supplies furnished by a Dentist to a Covered Person in order to diagnose or correct misalignment of the teeth or the bite.

Orthodontic Services are subject to the satisfaction of the Annual Deductible and payment of any applicable Copayments as described below.

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 TPA of such treatment before treatment begins. You must send the notice to the TPA, via claim form, within 20 days of the exam. If requested the Dentist must provide the TPA with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The TPA 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 TPA. 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.

WAITING PERIOD

No Waiting Period for Orthodontic Services.

NETWORK/NON-NETWORK COPAYMENT

A Network/Non-Network Copayment is the charge which you are required to pay for Orthodontic Services payable under the Plan. The Network/Non-Network Copayment is shown below as a percentage of Eligible Expense after the Annual Deductible is satisfied:

20% for Orthodontic Services rendered by a Network Dentist.

40% for Orthodontic Services rendered by a Non-Network Dentist. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.

ORTHODONTIC MAXIMUM

In a Covered Person lifetime:

$3,000 will be payable for Covered Orthodontic Services rendered by a Network Dentist; and

$1,500 will be payable for Covered Orthodontic Services rendered by a Non-Network Dentist.

The sum of all benefits payable for Covered Orthodontic Services rendered by Network and Non-Network Dentists in a Covered Person lifetime will not exceed $3,000 per Covered Person.

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