Southern Indiana School Trust
09062017SEGS, 09062017NDCS, 09062017NEDC, 09062017SSKS,
09062017SEDC, 09062017SWDC & 09062017SVCS

DENTAL EMPLOYEE BENEFIT PLAN

AND

SUMMARY PLAN DESCRIPTION

(Collectively referred to as “Planbook”)

Benefits & Network Administered By:

PARAMOUNT DENTAL
Affiliate of ProMedica

Connection Dental • DenteMax • Careington

Effective Date: January 1, 2023

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DISCLOSURES

The Plan is a self-funded dental employee welfare plan established by the Employer in accordance with the Employee Retirement Income Security Act of 1974, as amended from time to time, and other applicable law. This document serves as both the official plan document and summary plan description.

While the Employer fully intends to maintain the Plan indefinitely, it has reserved the right to amend, modify or terminate the Plan at any time. Changes in the Plan may include benefit coverage, deductibles, maximums, benefit percentages, exclusions, definitions, eligibility and the like. These benefits are intended to be excepted benefits and, therefore, not subject to the Affordable Care Act.

The Third Party Administrator (TPA) is Paramount Dental. Paramount Dental has contracted with the Employer to perform certain administrative functions only on behalf of the Plan Administrator.

The Employer will establish, and may from time to time change the contribution amounts required for coverage provided under the Plan for a Covered Person. The Employer will collect such contributions from the Covered Employees and combine such amounts with additional funding required by the Employer. Funding of the Plan is the sole responsibility of the Employer using Employee and Employer contributions. The TPA is not responsible for funding the payment of any claim for a Covered Person.

GENERAL INFORMATION

Name of Plan: Southern Indiana School Trust

Plan Number: Southern Indiana School Trust

Type of plan: Dental

Plan effective date: January 1, 2023Plan Year: January through December

Covered Employee: Employees (as defined within) who are employed by the Employer and in accordance with the terms and conditions of the Plan, has satisfied the requirements for coverage under the Plan until the coverage is terminated and who has been issued a Group Employee Benefit I.D. Card

Source of funding: Employer/Employee Contributions to Dental Employee Benefit Plan

Plan Administrator & Named Fiduciary:

Southern Indiana School Trust
5379 E Main St
Dubois, IN 47527

Third Party Administrator:
Paramount Dental
PO Box 659
Evansville, IN 47704-0659

COBRA Coordinator:
Southern Indiana School Trust
5379 E Main St
Dubois, IN 47527

Name and Title of Person(s) Designated as Agent for Service of Legal Process and Address at which Process may be served:
Southern Indiana School Trust
5379 E Main St
Dubois, IN 47527

INTRODUCTION

The Employer hereby establishes the benefits, rights and privileges which shall pertain to Covered Persons, as herein defined, and for whom dental benefits are provided through a fund established by the Employer and hereinafter referred to as the "Plan" or "Summary Plan Description."

Purpose
The purpose of this Summary Plan Description is to set forth the provisions of the Plan which relate to the payment of certain dental benefits.

Named Fiduciary
The Employer shall be the Named Fiduciary, unless otherwise indicated on the General Information page found within this booklet, within the meaning of Section 405(a) of ERISA.

Plan Administrator
The Employer shall be the Plan Administrator until the Employer has designated another party in writing as the Plan Administrator. The Employer shall also serve as the Plan Administrator for the period following the resignation of a Plan Administrator until a successor Plan Administrator has been appointed in writing.

The Plan Administrator has the following duties and responsibilities:

1. Maintain and retain Plan documents and records;
2. Interpret and administer the Plan in accordance with its terms and conditions;
3. Ratify or establish procedures relevant to the Plan;
4. Contract with third party vendors to provide services deemed appropriate under the Plan;
5. Answer questions and decide disputes relative to person's rights under the Plan;
6. Appoint or remove a Third Party Administrator;
7. Exercise general administrative authority over the Third Party Administrator;
8. Amend or terminate the Plan; and
9. Perform all necessary or required reporting.

The Plan Administrator has the discretionary authority to interpret the terms and conditions of the Plan, determine eligibility and benefits. Such interpretation, to the extent it is not in contradiction to the written terms and conditions of the Summary Plan Description, shall be binding upon the Employer, a Covered Person and a Third Party Administrator.

Contributions to the Plan
Contributions to the Plan are to be made on the following basis:

1. The Plan Administrator shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed (if any) by each Covered Employee.
2. Notwithstanding any other provision of the Plan, the Employer's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Employer's obligation with respect to such payments.
3. On and after the effective date of termination of the Plan, the obligation of the Employer to make additional contributions to the Plan shall be limited to the amount required to assure payment of benefits under the Plan for expenses incurred prior to such date of termination.

Amendment and Termination of the Plan
This Plan may be amended at any time by written resolution of the Plan Administrator's representatives. Said resolution and amendment shall state the effective date of the amendment and shall be communicated to all persons participating in this Plan as soon as possible after the amendment is adopted. Any amendment that reduces benefits under the Plan shall not be effective until first communicated to such persons.

If the Plan is amended or terminated, no Covered Employee or his Covered Dependent or beneficiary shall be entitled to receive any other benefit described in the Plan and shall not be entitled to receive any different type of coverage or replacement coverage. Upon termination of the Plan, in the event that the assets of the Plan are insufficient to fund claims incurred, the Plan Administrator shall have the sole and absolute discretion to make any pro rata or other adjustment of benefits, if necessary, so long as said adjustment is made in a non-discriminatory manner.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

Coverage provided under the Plan for Employees and their Dependents shall be in accordance with their Eligibility, Effective Date, and Termination provisions of the Plan Administrator, including any coverage classification. The Plan's Third Party Administrator will acknowledge the Plan Administrator's definition for Dependent(s) as long as the definition is compliant with the guidelines set forth by the U.S. Department of Health & Human Services, State and other Federal regulatory entities associated with health care regulations and oversight.

Open Enrollment
The open enrollment period is designated by the Employer and is usually the (30) day period immediately preceding the renewal date. During this period, the Employee may terminate coverage or change Dependent(s) coverage. An Employee that does not enroll themselves and their eligible Dependents within (30) days after the date of their eligibility must wait until open enrollment to enroll in the Plan.

Special Enrollment
Employees may not add, drop, or change coverage for themselves and/or Dependent(s) during the plan year unless Qualifying Event under HIPAA Special Enrollment, COBRA, or termination of employment occurs. A special enrollment period can occur if an Employee or Dependent(s) ceases to be covered under another health plan due to:

1. Loss of eligibility for coverage under the plan when COBRA continuation coverage is not elected; or
2. Expiration of COBRA continuation coverage;

A special enrollment period may also begin when Dependent(s) become newly eligibility due to:

1. Marriage, birth, court order, adoption or placement of a child in the home of the Employee

The Employee must request enrollment within 30 days of the Qualifying Event date. During the Special Enrollment Period, the Employee may enroll himself for coverage under the Plan. Subject to coverage of the Employee under the Plan, the Covered Employee may also enroll any newly eligible Dependents of the Employee under the Plan.

Qualified Medical child Support Order (QMCSO)
A QMCSO may require an Employee to provide coverage for a child without custody or for a child who is not the Covered Employee's dependent under the Plan. An Employee who is ordered by a QMCSO to provide dental coverage for a child may enroll himself/herself and such child under the Plan. Coverage shall be effective on the date the order is determined to be a QMCSO. Contact the Plan Administrator for more information regarding a QMCSO.

DENTAL BENEFITS AND EXCLUSIONS

Dental Benefit Percentage and Plan Year Deductible
Dental Benefits will be paid at the Dental Benefit Percentage as shown on the Schedule of Benefits. Benefits payable under the Plan, regardless of whether coverage under the Plan is continuous or not, shall be subject to a maximum annual benefit shown on the Schedule of Benefits. All covered services apply to the maximum annual benefit. Change of the dental plan coverage, termination, and reinstatement of coverage does not eliminate frequency limitations or maximum annual benefit used.

Allocation and Apportionment of Expenses
The Plan Administrator reserves the right to allocate the Plan Year Deductible to any Covered service and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment by the Plan Administrator shall be conclusive and shall be binding upon the Covered Person and all assignees.

Covered Services/Expenses
Covered Services under this Dental Benefits provision are charges for dental treatments and services furnished by a legally qualified Dentist acting within the lawful scope of his license. Dental treatments and Dental Benefits are subject to a General Exclusions provision, limitations and restrictions as disclosed on the Schedule of Benefits. No benefit will be paid, except to the extent benefits are otherwise indicated on the Schedule of Benefits.

Pre-Determination of Benefits
Covered Persons considering dental work may be required to send or have the Dentist send to the Plan's TPA, in advance, the plan of treatment being considered. The Plan's TPA will then, as soon as possible, advise the Covered Person and/or the Dentist of the benefits available.

Dental procedures requiring Pre-authorization of benefits, if any, are disclosed in your Schedule of Benefits. If a pre-authorization is not requested, the Plan Administrator reserves the right to pay the claim on the basis of the amount of benefits which would have been paid had pre-authorization been requested.

General Exclusions

All Plans and Certificates issued or administered by the Third Party Administrator are subject to the following general exclusions:

1. This Certificate will not pay for dental services that are not listed in the Summary Plan Description and Plan General Exclusions, Limitations and Restrictions attached to this Certificate.
2. This Certificate will not pay Claims for dental services rendered before the Effective Date or after coverage is terminated.
3. This Certificate will not pay Claims for dental services covered under non-dental insurance.
4. This Certificate will not pay Claims for charges made by hospitals.
5. This Certificate will not pay Claims for services performed primarily to rebuild occlusion or for full mouth reconstruction.
6. This Certificate will not pay Claims for Enrollees until HRI receives the appropriate contracted payment(s) for Premiums.
7. This Certificate will not pay Claims for services which are not completed.
8. This Certificate will not pay for duplicates, lost, or stolen prostheses or appliances.
9. To be considered for payment, a Claim must be within one year from the date of service.

PARAMOUNT DENTAL
Affiliate of ProMedica

Plan:
Southern Indiana School Trust

InsuringSmiles.com
Paramount Dental
Payor ID: CX019
PO Box 659 Evansville, IN 47704-0659

PLAN COVERED SERVICES & LIMITATIONS

ADA Code	Service Description	In/Out %
D0120	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT	100 / 100
D0140	LIMITED ORAL EVALUATION-PROBLEM FOCUSED	100 / 100
D0145	ORAL EVALUATION FOR A PATIENT UNDER 3 YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER	100 / 100
D0150	COMPREHENSIVE ORAL EVALUATION-NEW OR ESTABLISHED PATIENT	100 / 100
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT	100 / 100
D0170	RE-EVALUATION - LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT NOT POST-OPERATIVE VISIT)	100 / 100
D0180	COMPREHENSIVE PERIODONTAL EVALUATION-NEW OR ESTABLISHED PATIENT	100 / 100
D0210	INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES	100 / 100
D0220	INTRAORAL-PERIAPICAL FIRST RADIOGRAPHIC IMAGE	100 / 100
D0230	INTRAORAL-PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE	100 / 100
D0240	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE	100 / 100
D0270	BITEWING-SINGLE RADIOGRAPHIC IMAGE	100 / 100
D0272	BITEWINGS-TWO RADIOGRAPHIC IMAGES	100 / 100
D0273	BITEWINGS-THREE RADIOGRAPHIC IMAGES	100 / 100
D0274	BITEWINGS-FOUR RADIOGRAPHIC IMAGES	100 / 100
D0277	VERTICAL BITEWINGS-7 TO 8 RADIOGRAPHIC IMAGES	100 / 100
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION	100 / 100
D0321	OTHER TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES BY REPORT	100 / 100
D0330	PANORAMIC RADIOGRAPHIC IMAGE	100 / 100
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE ACQUISITION, MEASUREMENT AND ANALYSIS	100 / 100
D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGES OBTAINED INTRAORALLY OR EXTRAORALLY	100 / 100
D0372	INTRAORAL TOMOSYNTHESIS – COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES	100 / 100
D0373	INTRAORAL TOMOSYNTHESIS – BITEWING RADIOGRAPHIC IMAGE	100 / 100
D0374	INTRAORAL TOMOSYNTHESIS – PERIAPICAL RADIOGRAPHIC IMAGE	100 / 100
D0388	INTRAORAL TOMOSYNTHESIS – BITEWING RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100 / 100
D0389	INTRAORAL TOMOSYNTHESIS – PERIAPICAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100 / 100
D0460	PULP VITALITY TESTS	100 / 100
D0470	DIAGNOSTIC CASTS	100 / 100
D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100 / 100
D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100 / 100
D0703	2-D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY – IMAGE CAPTURE ONLY	100 / 100
D0706	INTRAORAL – OCCLUSAL RADIOGRAPHIC IMAGE	100 / 100

ADA Code	Service Description	In/Out %
D5214	MANDIBULAR PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50 / 50
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE-RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50 / 50
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50 / 50
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50 / 50
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50 / 50
D5225	MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)	50 / 50
D5226	MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)	50 / 50
D5511	REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR	50 / 50
D5512	REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY	50 / 50
D5520	REPLACE MISSING OR BROKEN TEETH-COMPLETE DENTURE (EACH TOOTH)	50 / 50
D5611	REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR	50 / 50
D5612	REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY	50 / 50
D5621	REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR	50 / 50
D5622	REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY	50 / 50
D5630	REPAIR OR REPLACE BROKEN CLASP-PER TOOTH	50 / 50
D5640	REPLACE BROKEN TEETH-PER TOOTH	50 / 50
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	50 / 50
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE PER TOOTH	50 / 50
D5670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)	50 / 50
D5671	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)	50 / 50
D5710	REBASE COMPLETE MAXILLARY DENTURE	50 / 50
D5711	REBASE COMPLETE MANDIBULAR DENTURE	50 / 50
D5720	REBASE MAXILLARY PARTIAL DENTURE	50 / 50
D5721	REBASE MANDIBULAR PARTIAL DENTURE	50 / 50
D5730	RELINE COMPLETE MAXILLARY DENTURE (DIRECT)	50 / 50
D5731	RELINE COMPLETE MANDIBULAR DENTURE (DIRECT)	50 / 50

	– IMAGE CAPTURE ONLY	
D0707	INTRAORAL – PERIAPICAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100 / 100
D0708	INTRAORAL – BITEWING RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100 / 100
D0709	INTRAORAL – COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES – IMAGE CAPTURE ONLY	100 / 100
D1110	PROPHYLAXIS-ADULT	100 / 100
D1120	PROPHYLAXIS-CHILD	100 / 100
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	100 / 100
D1208	TOPICAL APPLICATION OF FLUORIDE-EXCLUDING VARNISH	100 / 100
D1351	SEALANT-PER TOOTH (PERMANENT MOLAR TEETH)	100 / 100
D1510	SPACE MAINTAINER-FIXED, UNILATERAL - PER QUADRANT	100 / 100
D1516	SPACE MAINTAINER-FIXED-BILATERAL,MAXILLARY	100 / 100
D1517	SPACE MAINTAINER-FIXED-BILATERAL,MANDIBULAR	100 / 100
D1520	SPACE MAINTAINER - REMOVABLE - UNILATERAL - PER QUADRANT	100 / 100
D1526	SPACE MAINTAINER-REMOVABLE-BILATERAL,MAXILLARY	100 / 100
D1527	SPACE MAINTAINER-REMOVABLE-BILATERAL,MANDIBULAR	100 / 100
D1551	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MAXILLARY	100 / 100
D1552	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MANDIBULAR	100 / 100
D1553	RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER - PER QUADRANT	100 / 100
D1575	DISTAL SHOE SPACE MAINTAINER - FIXED, UNILATERAL - PER QUADRANT	100 / 100
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	90 / 90
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT	90 / 90
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT	90 / 90
D2161	AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	90 / 90
D2330	RESIN-BASED COMPOSITE-ONE SURFACE, ANTERIOR	90 / 90
D2331	RESIN-BASED COMPOSITE-TWO SURFACES, ANTERIOR	90 / 90
D2332	RESIN-BASED COMPOSITE-THREE SURFACES, ANTERIOR	90 / 90
D2335	RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)	90 / 90
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR (PRIMARY ONLY)	90 / 90
D2391	RESIN-BASED COMPOSITE-ONE SURFACE, POSTERIOR	90 / 90
D2392	RESIN-BASED COMPOSITE-TWO SURFACES, POSTERIOR	90 / 90
D2393	RESIN-BASED COMPOSITE-THREE SURFACES, POSTERIOR	90 / 90
D2394	RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES, POSTERIOR	90 / 90
D2520	INLAY-METALLIC-TWO SURFACES	90 / 90
D2530	INLAY-METALLIC-THREE OR MORE SURFACES	90 / 90
D2542	ONLAY-METALLIC-TWO SURFACES	90 / 90
D2543	ONLAY-METALLIC-THREE SURFACES	90 / 90
D2544	ONLAY-METALLIC-FOUR OR MORE SURFACES	90 / 90
D2610	INLAY-PORCELAIN/CERAMIC-ONE SURFACE	90 / 90
D2620	INLAY-PORCELAIN/CERAMIC-TWO SURFACES	90 / 90
D2630	INLAY-PORCELAIN/CERAMIC-THREE OR MORE SURFACES	90 / 90
D2642	ONLAY-PORCELAIN/CERAMIC-TWO SURFACES	90 / 90
D2643	ONLAY-PORCELAIN/CERAMIC-THREE SURFACES	90 / 90
D2644	ONLAY-PORCELAIN/CERAMIC-FOUR OR MORE SURFACES	90 / 90
D5740	RELINE MAXILLARY PARTIAL DENTURE (DIRECT)	50 / 50
D5741	RELINE MANDIBULAR PARTIAL DENTURE (DIRECT)	50 / 50
D5750	RELINE COMPLETE MAXILLARY DENTURE (INDIRECT)	50 / 50
D5751	RELINE COMPLETE MANDIBULAR DENTURE (INDIRECT)	50 / 50
D5760	RELINE MAXILLARY PARTIAL DENTURE (INDIRECT)	50 / 50
D5761	RELINE MANDIBULAR PARTIAL DENTURE (INDIRECT)	50 / 50
D5820	INTERIM PARTIAL DENTURE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MAXILLARY	50 / 50
D5821	INTERIM PARTIAL DENTURE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MANDIBULAR	50 / 50
D5850	TISSUE CONDITIONING, MAXILLARY	50 / 50
D5851	TISSUE CONDITIONING, MANDIBULAR	50 / 50
D5863	OVERDENTURE-COMPLETE MAXILLARY	50 / 50
D5864	OVERDENTURE-PARTIAL MAXILLARY	50 / 50
D5865	OVERDENTURE-COMPLETE MANDIBULAR	50 / 50
D5866	OVERDENTURE-PARTIAL MANDIBULAR	50 / 50
D6010	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	90 / 90
D6013	SURGICAL PLACEMENT OF MINI IMPLANT	90 / 90
D6056	PREFABRICATED ABUTMENT-INCLUDES PLACEMENT	90 / 90
D6057	CUSTOM ABUTMENT-INCLUDES PLACEMENT	90 / 90
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	90 / 90
D6059	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	90 / 90
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL)	90 / 90
D6061	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)	90 / 90
D6062	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	90 / 90
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D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	90 / 90
D6066	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	90 / 90
D6067	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	90 / 90
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	50 / 50
D6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	50 / 50
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINANTLY BASE METAL)	50 / 50
D6071	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	50 / 50
D6072	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	50 / 50
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINANTLY BASE METAL)	50 / 50
D6074	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	50 / 50
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	50 / 50
D6076	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	50 / 50
D6077	IMPLANT SUPPORTED RETAINER FOR METAL FPD - HIGH NOBLE ALLOYS	50 / 50
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUOSITIS	90 / 90

D2651	INLAY-RESIN-BASED COMPOSITE-TWO SURFACES	90 / 90
D2652	INLAY-RESIN-BASED COMPOSITE-THREE OR MORE SURFACES	90 / 90
D2663	ONLAY-RESIN-BASED COMPOSITE-THREE SURFACES	90 / 90
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D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	90 / 90
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D2751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	90 / 90
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	90 / 90
D2753	CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	90 / 90
D2780	CROWN-3/4 CAST HIGH NOBLE METAL	90 / 90
D2781	CROWN-3/4 CAST PREDOMINANTLY BASE METAL	90 / 90
D2782	CROWN-3/4 CAST NOBLE METAL	90 / 90
D2783	CROWN-3/4 PORCELAIN/CERAMIC	90 / 90
D2790	CROWN-FULL CAST HIGH NOBLE METAL	90 / 90
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	90 / 90
D2792	CROWN-FULL CAST NOBLE METAL	90 / 90
D2794	CROWN-TITANIUM AND TITANIUM ALLOYS	90 / 90
D2799	INTERIM CROWN – FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	90 / 90
D2910	RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION	90 / 90
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D2940	PROTECTIVE RESTORATION	90 / 90
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D2951	PIN RETENTION, PER TOOTH, IN ADDITION TO RESTORATION	90 / 90
D2952	POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED	90 / 90
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	90 / 90
D2960	LABIAL VENEER (RESIN LAMINATE) – DIRECT	90 / 90
D2962	LABIAL VENEER (PORCELAIN LAMINATE) – INDIRECT	90 / 90
D2971	ADDITIONAL PROCEDURES TO CUSTOMIZE A CROWN TO FIT UNDER AN EXISTING PARTIAL DENTURE FRAMEWORK	90 / 90
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D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)-REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT	90 / 90
D3230	PULPAL THERAPY (RESORBABLE FILLING)-ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	90 / 90
D3240	PULPAL THERAPY (RESORBABLE FILLING)-POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	90 / 90
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)	90 / 90
D3320	ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION)	90 / 90
D3330	ENDODONTIC THERAPY, MOLAR (EXCLUDING	90 / 90
	OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE	
D6082	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS	90 / 90
D6083	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO NOBLE ALLOYS	90 / 90
D6084	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	90 / 90
D6086	IMPLANT SUPPORTED CROWN - PREDOMINANTLY BASE ALLOYS	90 / 90
D6087	IMPLANT SUPPORTED CROWN - NOBLE ALLOYS	90 / 90
D6088	IMPLANT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS	90 / 90
D6092	RE-CEMENT RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	90 / 90
D6094	ABUTMENT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS	90 / 90
D6097	ABUTMENT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	90 / 90
D6098	IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS	50 / 50
D6099	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO NOBLE ALLOYS	50 / 50
D6110	IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH-MAXILLARY	50 / 50
D6111	IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH-MANDIBULAR	50 / 50
D6112	IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH-MAXILLARY	50 / 50
D6113	IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH-MANDIBULAR	50 / 50
D6114	IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH-MAXILLARY	50 / 50
D6115	IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH-MANDIBULAR	50 / 50
D6116	IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH-MAXILLARY	50 / 50
D6117	IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH-MANDIBULAR	50 / 50
D6120	IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50 / 50
D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	50 / 50
D6195	ABUTMENT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50 / 50
D6210	PONTIC-CAST HIGH NOBLE METAL	50 / 50
D6211	PONTIC-CAST PREDOMINANTLY BASE METAL	50 / 50
D6212	PONTIC-CAST NOBLE METAL	50 / 50
D6214	PONTIC-TITANIUM AND TITANIUM ALLOYS	50 / 50
D6240	PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL	50 / 50
D6241	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	50 / 50
D6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL	50 / 50
D6243	PONTIC - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50 / 50
D6245	PONTIC-PORCELAIN/CERAMIC	50 / 50
D6545	RETAINER-CAST METAL FOR RESIN BONDED FIXED PROSTHESIS	50 / 50
D6548	RETAINER-PORCELAIN/CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	50 / 50
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	50 / 50
D6750	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	50 / 50
D6751	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	50 / 50

	FINAL RESTORATION)	
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-ANTERIOR	90 / 90
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-BICUSPID	90 / 90
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-MOLAR	90 / 90
D3351	APEXIFICATION/RECALCIFICATION-INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC)	90 / 90
D3352	APEXIFICATION/RECALCIFICATION-INTERIM MEDICATION REPLACEMENT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION, ETC)	90 / 90
D3353	APEXIFICATION/RECALCIFICATION-FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY-APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC)	90 / 90
D3410	APICOECTOMY-ANTERIOR	90 / 90
D3421	APICOECTOMY-BICUSPID (FIRST ROOT)	90 / 90
D3425	APICOECTOMY - MOLAR (FIRST ROOT)	90 / 90
D3426	APICOECTOMY (EACH ADDITIONAL ROOT)	90 / 90
D3430	RETROGRADE FILLING-PER ROOT	90 / 90
D3450	ROOT AMPUTATION-PER ROOT	90 / 90
D3920	HEMISECTION (INCLUDING ANY ROOT REMOVAL), NOT INCLUDING ROOT CANAL THERAPY	90 / 90
D3950	CANAL PREPARATION AND FITTING OF PREFORMED DOWEL OR POST	90 / 90
D4210	GINGIVECTOMY OR GINGIVOPLASTY-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	90 / 90
D4249	CLINICAL CROWN LENGTHENING-HARD TISSUE	90 / 90
D4260	OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE)-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	90 / 90
D4261	OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE)-ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	90 / 90
D4266	GUIDED TISSUE REGENERATION, NATURAL TEETH – RESORBABLE BARRIER, PER SITE	90 / 90
D4267	GUIDED TISSUE REGENERATION, NATURAL TEETH – NON-RESORBABLE BARRIER, PER SITE	90 / 90
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	90 / 90
D4273	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT	90 / 90
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	90 / 90
D4275	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT (INCLUDING RECIPIENT SITE AND DONOR MATERIAL) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT	90 / 90
D4277	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT	90 / 90
D4278	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES) EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	90 / 90
D4283	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES)-EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	90 / 90
D4285	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT	90 / 90
D6752	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	50 / 50
D6753	RETAINER CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50 / 50
D6780	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	50 / 50
D6781	RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	50 / 50
D6782	RETAINER CROWN - 3/4 CAST NOBLE METAL	50 / 50
D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	50 / 50
D6784	RETAINER CROWN 3/4 - TITANIUM AND TITANIUM ALLOYS	50 / 50
D6790	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	50 / 50
D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	50 / 50
D6792	RETAINER CROWN - FULL CAST NOBLE METAL	50 / 50
D6794	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	50 / 50
D6930	RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE	50 / 50
D6940	STRESS BREAKER	50 / 50
D7111	EXTRACTION, CORONAL REMNANTS-DECIDUOUS TOOTH	90 / 90
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	90 / 90
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	90 / 90
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	90 / 90
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	90 / 90
D7240	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY	90 / 90
D7241	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS	90 / 90
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	90 / 90
D7251	CORONECTOMY – INTENTIONAL PARTIAL TOOTH REMOVAL, IMPACTED TEETH ONLY	90 / 90
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH	90 / 90
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	90 / 90
D7283	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH	90 / 90
D7286	INCISIONAL BIOPSY OF ORAL TISSUE-SOFT	90 / 90
D7291	TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT	90 / 90
D7310	ALVEOLOPLASTY IN CONJUCTION WITH EXTRACTIONS-FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	90 / 90
D7311	ALVEOLOPLASTY IN CONJUCTION WITH EXTRACTIONS-ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	90 / 90
D7320	ALVEOLOPLASTY NOT IN CONJUCTION WITH EXTRACTIONS-FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	90 / 90
D7321	ALVEOLOPLASTY NOT IN CONJUCTION WITH EXTRACTIONS-ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	90 / 90
D7340	VESTIBULOPLASTY-RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	90 / 90
D7350	VESTIBULOPLASTY-RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE)	90 / 90
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM	90 / 90
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	90 / 90

	SURGICAL SITE AND DONOR MATERIAL)-EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	
D4341	PERIODONTAL SCALING AND ROOT PLANING-FOUR OR MORE TEETH PER QUADRANT (4 TEETH WITH 4+MM POCKETS)	90 / 90
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION - FULL MOUTH, AFTER ORAL EVALUATION	90 / 90
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE A COMPREHENSIVE PERIODONTAL EVALUATION AND DIAGNOSIS ON A SUBSEQUENT VISIT	90 / 90
D4910	PERIODONTAL MAINTENANCE	90 / 90
D5110	COMPLETE DENTURE-MAXILLARY	50 / 50
D5120	COMPLETE DENTURE-MANDIBULAR	50 / 50
D5130	IMMEDIATE DENTURE-MAXILLARY	50 / 50
D5140	IMMEDIATE DENTURE-MANDIBULAR	50 / 50
D5211	MAXILLARY PARTIAL DENTURE-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	50 / 50
D5212	MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	50 / 50
D5213	MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50 / 50
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP TO 1.25 CM	90 / 90
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25 CM	90 / 90
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)	90 / 90
D7472	REMOVAL OF TORUS PALATINUS	90 / 90
D7473	REMOVAL OF TORUS MANDIBULARIS	90 / 90
D7509	MARSUPIALIZATION OF ODONTOGENIC CYST	80 / 80
D7510	INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE	90 / 90
D7511	INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE-COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)	90 / 90
D7830	MANIPULATION UNDER ANESTHESIA	90 / 90
D7922	PLACEMENT OF INTRA-SOCKET BIOLOGICAL DRESSING TO AID IN THE HEMOSTASIS OR CLOT STABILIZATION, PER SITE	90 / 90
D7961	BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY)	90 / 90
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	90 / 90
D7970	EXCISION OF HYPERPLASTIC TISSUE-PER ARCH	90 / 90
D7971	EXCISION OF PERICORONAL GINGIVA	90 / 90
D7980	SIALOLITHOTOMY	90 / 90
D9110	PALLIATIVE TREATMENT OF DENTAL PAIN – PER VISIT	90 / 90
D9944	OCCLUSAL GUARD-HARD APPLIANCE, FULL ARCH	90 / 90
D9945	OCCUSAL GUARD-SOFT APPLIANCE, FULL MOUTH	90 / 90
D9946	OCCLUSAL GUARD-HARD APPLIANCE,PARTIAL ARCH	90 / 90

PLAN GENERAL EXCLUSIONS, LIMITATIONS AND RESTRICTIONS, including provider supporting documentation requirements

Eligibility is determined by the last date(s) of service and not based on a calendar or plan year. The last date(s) of service are determined by the prior completion date(s) in which the enrollee was eligible to receive benefits. Covered services for which a patient is not eligible, may be billed to the patient. Covered services that are disallowed by the plan, may not be billed to the patient.

ADA Range	Provider Rule
D0120, D0145, D0160, D0170	Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period.
D0140	An evaluation limited to a specific oral health problem or complaint. The use of this procedure code is also appropriate in dental emergencies, trauma, acute infection, etc. Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period.
D0150, D0180	Eligible only once every 4 years. D0180 applies to age 14 and above. Charges will be disallowed if performed in conjunction with D4355. Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period.
D0210, D0372, D0709	A complete series includes bitewings. Eligible only once per 4 years. Not eligible if performed within 4 years of D0330, D0701 or D0709. If D0210 is performed within 12 months of D0270, D0272, D0273, D0274, D0708 the allowable amount for D0210 will be reduced by the charges for D0270, D0272, D0273, D0274, D0708. Not eligible if performed within 12 months of D0277. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0220, D0230, D0374, D0389, D0707	Eligible for a maximum of 3 during a 12 month period. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0240	Eligible only once per arch per 12 months. Not eligible if performed within 12 months of D0706. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0270, D0373, D0388, D0708	“Bitewing” radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210, D0277 or D0709. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0272, D0273	Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. “Bitewing” radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277.
D0274	“Bitewing” radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. “Bitewing” radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277.
D0277	Not eligible if performed within 12 months of D0210 or D0274. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0320, D0321	Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0330, D0701	Eligible only once per 4 years. Not eligible if performed within 4 years of D0210, D0701 or D0709. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0340	Eligible only once per 2 years. Not eligible if performed within 2 years of D0702. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D0350, D0703	Eligible only once per 5 years. Not eligible if performed within 4 years of D0703. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D0460	Eligible for one charge per date of service.
D0470	Eligible only once per 5 years. It is included in the charges for complete or partial dentures, separate charges are disallowed. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D0702	Eligible only once per 2 years. Not eligible if performed within 2 years of D0340. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D0706	Eligible only once per arch per 12 months. Not eligible if performed within 12 months of D0240. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D1110, D1120	Not eligible for more than 2 cleanings per 12 consecutive month period which includes utilization of codes D4341, D4346, D4355, or D4910. Reimbursement for D1120 is limited to enrollees under the age of 14.
D1206	Not eligible for more than 2 fluoride treatments per 12 consecutive month period. Eligible only for children under 14 years of age.
D1208	Not eligible for more than 2 fluoride treatments per 12 consecutive month period. Age limitation may apply.
D1351	Eligible on permanent molar teeth (per tooth) only. Not eligible for replacement for a period of 5 years. Eligible only for children under 15 years of age. Not eligible for a restoration on the O, OB, or OL surfaces following the placement of a sealant on that surface or if a restoration involving the O surfaces has been performed for a period of 3 years.
D1510, D1516, D1517, D1520, D1526, D1527, D1575	Eligible only for children under 13 years of age. Not eligible if performed within 3 years of D1510, D1515, D1520, D1525, or D1575.
D1551, D1552, D1553	Not eligible within 12 months of the initial placement of the space maintainer. Eligible once per 12 months.
D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391,	Not eligible for the replacement of or an additional restoration on the same surface for a period of 2 years. Not eligible if performed within 3 years of placing a crown on the same tooth or a sealant on the same surface within 3 years. If two or more restorations are performed on the same tooth, on the same date of service, only the total number of unique surfaces will be considered.

D2392, D2393, D2394	
D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2651, D2652, D2663, D2664, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794	Not eligible for a replacement by any type of inlay, onlay, or crown for 5 years. A charge for a crown following the placement of a restoration is not eligible for a period of 3 years (a courtesy adjustment may be applied). Crowns, other than prefabricated steel crowns, are not eligible for primary teeth. Composite/resin inlays must be laboratory processed.
D2710	Eligible on anterior teeth only. Not eligible for a replacement by any type of inlay, onlay, or crown for 5 years. A charge for a crown following the placement of a restoration is not eligible for a period of 3 years (a courtesy adjustment may be applied). Crowns, other than prefabricated steel crowns, are not eligible for primary teeth. Composite/resin inlays must be laboratory processed.
D2910, D2915, D2920, D6092	Not eligible for the recementation of an inlay, onlay, or crown within 12 months of the original cementation. Eligible once per 12 months.
D2930, D2931, D2933, D2934	Charges are subject to the same restrictions and conditions as D2520 through D2794.
D2940	Not eligible for replacement by another protective restoration for a period of 3 years. Not eligible if performed in conjunction with endodontics, an amalgam/composite restoration, inlay, onlay, crown, or fixed prosthesis retainer prepared or cemented at the same appointment. Charges for definitive treatment are subject to an adjustment if performed within 12 months of D2940.
D2950	Not eligible within 3 years of restoration and/or replacement within 7 years on the same tooth. Coverage for core buildups requires the submission of a duplicate, diagnostically acceptable, pre-operative radiographic image or intraoral photo that substantiates one of the following three criteria: 1) more than 50% of the tooth crown is missing due to fracture or decay; 2) less than 3 mm of sound tooth structure remaining around the gum line; 3) previous root canal filling completed except where a prior crown through which the access is made remains on the tooth. Charges not meeting established criteria will be disallowed.
D2951	Charge is per tooth and limited to posterior teeth only. Additional pins will be disallowed.
D2952, D2954	Not eligible if performed within 7 years of D2950, D2952, or D2954. Eligible once per 7 years per tooth. Not allowable without history of root canal therapy.
D2960	Not eligible for a replacement for 3 years. Placement is restricted to anterior permanent teeth only.
D2962	Not eligible for a replacement for 7 years. Placement is restricted to anterior permanent teeth only. Charges for veneered crowns replacing labial veneers (porcelain) are not allowable for 7 years.
D3220	Eligible for primary teeth only and only once per tooth. Charges are exclusive of the final restoration charge.
D3230	Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. Separate fees for radiographs are disallowed. Charges are exclusive of the final restoration charge. Charges for “elective” root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.
D3240	Eligible on primary posterior teeth only. Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. Separate fees for radiographs are disallowed. Charges are exclusive of the final restoration charge. Charges for “elective” root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.
D3310, D3320, D3330, D3346, D3347, D3348	Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. A single periapical will be considered however, fees for any additional radiographs will be disallowed. Charges are exclusive of the final restoration charge. Charges for “elective” root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.
D3351, D3352, D3353	Limited to children under 16 years of age. Eligible once per lifetime. Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. A single periapical will be considered however, fees for any additional radiographs will be disallowed. Charges are exclusive of the final restoration charge. Charges for “elective” root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.
D3410, D3421, D3425, D3426, D3430, D3450, D3920	Eligible once per lifetime.
D3950	Eligible once per 7 years. Charges will be disallowed if submitted in conjunction with D2952, D2953, D2954, or D2957.
D4210, D4260, D4261	Eligible only once per area treated for a 5 year period.
D4249	Eligible only once on a per tooth basis. Eligible only once per area treated for a 5 year period.
D4266, D4267	Charges include the charge for the barrier, and its removal, if necessary. Eligible only once per area treated for a 5 year period.
D4270, D4273, D4275, D4277, D4278	Two soft tissue grafts of any type are eligible per quadrant every 5 years. Teeth #24-25 are considered one site. Eligible only once per area treated for a 5 year period.
D4274	Eligible only when this procedure is performed in an edentulous area adjacent to a periodontally involved tooth. The tooth and proximal area must be identified. Eligible only if no additional surgery is performed in the immediate area, eligible every 5 years. Eligible only once per area treated for a 5 year period.
D4283, D4285	Two soft tissue grafts of any type are eligible per quadrant every 5 years. Teeth #24-25 are considered one site.

D4341	Eligible per quadrant (4 or more active periodontal diseased and qualified teeth). The enrollee must exhibit pocket depths of at least 4 mm around at least 4 teeth in each quadrant to qualify for coverage for this procedure. Otherwise refer to D1110 and D4355. Not eligible on deciduous teeth. Not eligible for retreatment of any quadrant for 3 years. Charges require the submission of full mouth probe chart with six points per tooth probings AND diagnostic full mouth radiographs and/or vertical bitewings. Only two quadrants are considered on the same date of service, additional quadrants will be disallowed. Separate charges for local anesthetic are disallowed. A D1110 cannot be charged within 6 months if 4 quadrants of D4341/D4342 are performed. Charges not meeting established criteria will be disallowed. A pretreatment is suggested. Dental Review Team maintains discretionary authority regarding review requirements.
D4346	Eligible only for enrollees over 15 years of age. Eligible once per 5 years. Not eligible within 6 months of or same date of service as D1110, D1120, D4341/D4342 (quadrant allottment may apply), D4355, or D4910.
D4355	Eligible only for enrollees over 15 years of age. To be eligible, procedure must be performed before and not on the same date of service as D1110, D4341, D4342, D4346, or D4910, or more than 3 years has lapsed since D1110, D4341, D4342, D4346, D4355, or D4910 was performed.
D4910	Not eligible if performed within 6 months of or same date of service as D1110, D1120, D4341/D4342 if four quadrants were treated, D4346 or D4355. Not eligible for more than 2 per 12 consecutive month period. Eligible only for enrollees over 15 years of age.
D5110, D5120	Not eligible for the replacement of a denture, including an immediate or partial denture, within 7 years. Separate charges for diagnostic casts (D0470) are disallowed. Charges for a conventional, removable partial dentures or a complete denture (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, and D5226) are subject to an adjustment if performed within 5 years of an interim partial denture (D5820 & D5821) in the same arch or of any repairs, relines, rebases (D5510 through D5761).
D5130, D5140	An immediate denture cannot be used to replace a complete denture. Other restrictions are the same as D5110 & D5120.
D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226	Eligible every 7 years and are subject to the same conditions and restrictions listed for D5110 & D5120. Separate charges for diagnostic casts (D0470) are disallowed. The teeth replaced by the appliance must be identified on the claim form.
D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660	Not eligible if the procedure is performed within 6 months of the date of delivery of the appliance. Eligible once per procedure code per 6 months.
D5670, D5671	Eligible only once per 4 years per prosthesis. Not eligible if performed within 4 years of D5213 or D5214. Not eligible for charges for rebase, reline or repairs for 6 months.
D5710, D5711, D5720, D5721, D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761	Not eligible within 6 months of the date of delivery of the appliance except when an immediate partial/denture is performed. Eligible for any of these procedures only once per 4 years per prosthesis.
D5820, D5821	Charges for a conventional, removable partial dentures or a complete denture (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, and D5226) are subject to an adjustment if performed within 5 years of an interim partial denture (D5820 & D5821) in the same arch.
D5850, D5851	Eligible for two tissue conditioning charges within 6 months of delivery of immediate partial/denture only.
D5863, D5864, D5865, D5866	Charges are subject to the conditions listed for D5110/D5120 and D5213/D5214.
D6010, D6013, D6056, D6057	Eligible once per 7 years per tooth site. Allowance includes the treatment plan, local anesthetic and post-surgical care. Coverage is limited to enrollees over 15 years of age. Pre-existing conditions do not apply.
D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6194, D6195	Charges are subject to the same definitions and restrictions listed for D2710 thru D2794 and D6210 thru D6974. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.
D6081	Eligible 12 months after the original placement of the implant. Not eligible for retreatment for a period of 3 years. Not eligible if performed on the same date of service as D1110, D4341, D4342, D4346, D4355, or D4910.
D6110, D6111, D6112, D6113, D6114, D6115, D6116, D6117	Charges are subject to the same definitions and restrictions listed for D5110 thru D5866. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.
D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6545, D6548, D6740, D6750, D6751,	Charges are subject to the same definitions and restrictions listed for D2520 thru D2794. Each unit of a fixed partial denture must be identified on the claim. Not eligible for pontics to replace third molars. All fix prosthodontic services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. Not eligible for replacement of a removable partial denture by a fixed partial denture within 7 years of the original placement.

D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794	
D6930	Not eligible within 12 months of the original cementation. Eligible only once per 12 months per fixed partial denture.
D7210, D7250	Surgical extractions: use when either (1) removal of bone and/or (2) sectioning of tooth, including elevation of mucoperiosteal flap if indicated, is necessary. Surgical extraction charges include alveoloplasty. Primary teeth, teeth 7-10 and 23-26 require the submission of a duplicate, diagnostically acceptable, pre-operative periapicial and/or panoramic radiograph with claim submission. Charges not meeting established criteria will be disallowed.
D7280, D7283	Eligible once per lifetime. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D7286	Charges will be disallowed in performed in conjunction with D3410, D3421, D3425, D3426, or D3427.
D7291	Eligible on anterior permanent teeth and bicuspids. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D7310, D7311	Charges are subject to review if performed in conjunction with D7210 thru D7250. Charges not meeting generally accepted standards of care will be disallowed (see D7210 thru D7250).
D7340, D7350	Charges filed in conjunction with implant services will be disallowed.
D7473	Eligible once per arch per lifetime.
D7510	Charges filed in conjunction with definitive treatment will be disallowed.
D7922	Not eligible for more than a combination of two D7922 or D9110 per 12 month period. Charges filed in conjunction with definitive treatment will be disallowed.
D7961, D7962	Eligible once per lifetime. Charges are subject to review if performed in conjunction with definitive treatment. Charges not meeting generally accepted standards of care will be disallowed.
D7971	Charges filed in conjunction with definitive restorative treatment will be disallowed.
D9110	Not eligible for more than two palliative (emergency) treatments per 12 month period. Charges filed in conjunction with definitive treatment will be disallowed.
D9944, D9945, D9946	Occlusal guards are removable dental appliances designed to minimize the effects of bruxism and other occlusal factors. Eligible once every 5 years. Charges to modify the appliance or for occlusal adjustment are not eligible.

ORTHODONTIC BENEFIT RIDER

Type
B – Ortho Dependent Child Only

Benefits are paid on a payment cycle as determined by your Employer's Master Group.

Limited Orthodontic Treatment
Comprehensive Orthodontic Treatment
Interceptive Orthodontic Treatment
Treatment to Control Harmful Habits

1. Claims for orthodontic services are allowable only until the earlier of 1) Plan coverage ends, or 2) the covered dependent reaches the employer group's maximum dependent age, whether or not treatment has been completed or lifetime maximum orthodontics benefits have been paid.
2. Benefit payments for orthodontic services are IN ADDITION to the maximum annual benefit payments for non-orthodontic services.
3. The above listed services are payable at a rate of 50% of total billed charges up to the lifetime maximum benefit, not to exceed the maximum monthly installment.

Lifetime Orthodontic Maximum	Maximum Monthly Installment
$1,000.00	$41.70
$1,200.00	$50.00
$1,500.00	$62.50
$2,000.00	$83.40

Refer to the Enrollee's Plan to confirm 1) orthodontic type and 2) lifetime orthodontic maximum.

4. In order to receive the maximum lifetime benefit, patient must be in active orthodontic treatment a minimum of two years while covered by a Plan with an applicable orthodontic rider.
5. Active treatment is defined as treatment resulting in the movement of teeth, periodic visits, and/or retention period.
6. A lifetime maximum benefit is the maximum amount the plan will pay in orthodontic benefits to a covered person during that individual's lifetime. Once an individual has exhausted his/her lifetime maximum benefit under any Plan, additional charges will be excluded.
7. The dentist providing orthodontic services must identify on the claim form 1) when orthodontic services began, 2) the estimated total time for treatment, and 3) the total cost for treatment. The Plan will auto-generate the appropriate monthly benefit in accordance with the treatment plan designated on the claim form. Therefore, monthly claim submission may be required.
8. Benefits may be paid even if orthodontic services began before dental coverage. The total cost for treatment will be divided between two periods:
   a. Period #1: the date treatment started to the date dental coverage began (this cost will NOT be covered);
   b. Period #2: the date dental coverage began to the date when treatment should be completed (this cost will be covered for the time REMAINING in the treatment program)
9. Orthodontic rider does not include benefits for lost, stolen, or replacement retainers.

Payments are subject to the limitations previously described.

PROCEDURES FOR OBTAINING DENTAL SERVICES

Dentistry is a highly personal service. Covered Persons may have any dental treatment performed as decided by the patient and the dentist. The Plan does not dictate the treatment received, as only the patient and dentist can determine that. However, the Plan does determine what services are covered and by what type of dentist (In-Network vs. Out-of-Network). The Plan selected by the Employer pays for only those Covered Services listed in this booklet within the limitations and restrictions presented. The patient must personally pay for any service which is not covered or for any service that is covered but is subject to limitations and restrictions. Claims will only be processed after completion of the dental procedure. If a Covered Person is not sure whether a particular dental treatment is covered or how much he will be required to pay, the Covered Person may request a Pre-Treatment Estimate from his dentist. It is a free service offered by the Third Party Administrator.

Some services are limited by the age of the patient, by how often the procedure may be performed, or by specific teeth. All time intervals (frequency limitations) required by coverage are independent of calendar year or plan year. Frequency limitations regarding how often services may be performed are continuous. Change of dental plan coverage, termination and reinstatement of coverage does not eliminate the frequency limitations.

The Plan also offers a large, nationwide network of credentialed dentist to accommodate oral health needs of each Covered Person. Simply visit the Find a Dentist link on InsuringSmiles.com, to view a complete listing of general and specialty Network Dentist in the desired geographical area.

Your Employer has selected an In and Out of Network Plan.

(In-Network and Out-of-Network Plan Option)
This option is a flexible plan that offers the payment of Benefits to either an In-Network Dentist or an Out-of-Network Dentist. You have the freedom to visit any dentist of your choice. However, your dentist choice can make a difference in the amount you pay. Choosing a dentist in the Network results in greater cost savings to you and less out of pocket costs. Any differences between the Network Dentist's actual charges and the contracted maximum allowed amount MAY NOT be balanced billed to you. The Network Dentist is required to adjust his/her bill for this difference. This is referred to as "no Balance Billing", so you benefit from HRI's negotiated savings. As an added convenience, when you visit a Network Dentist, the dentist files the Claim for you and the Company pays the dentist directly. Visit the Find a Dentist link on [InsuringSmiles.com] to review a listing of Network Dentists' services.

Out-of-Network Dentists are under no obligation to file Claims on your behalf, assist with your insurance benefits, or accept contracted fees. Reimbursement for services not provided by a Network Dentist will be paid upon a scheduled table of allowances. There may be a payment difference between the allowed reimbursement and the amount the dentist charges for a particular service, which could result in greater out of pocket costs for you. This amount may be significant. This is referred to as Balance Billing. Therefore, services may not be covered at 100% and your co-insurance may be a greater percentage of the dentist's fees if the charged fees exceed the allowable amount. You may also be required to file your own dental Claims and pay 100% for your dental services at time of visit.

PROCEDURES FOR REIMBURSEMENT OF COVERED EXPENSES

In-Network Dentist Expenses
In Network Dentists are responsible for submitting claims to the TPA on a Covered Person's behalf for services they render. The Plan shall reimburse the In-Network Dentist directly for Covered Expenses.

A Covered Person is responsible for the Deductible and any out-of-pocket expenses required by the Plan including the cost of services that are not covered by the Plan. If a Covered Person is billed by an In-Network Dentist for a Covered Service (other than the Deductible or co-insurance/out-of-pocket expense), a Covered Person should contact the In-Network Dentist. Contact the TPA if the In-Network Dentist continues to bill for such expenses.

Out-of-Network Dentist Expenses
A Covered Person is ultimately responsible for submitting claims to the TPA for all Covered Expenses rendered by Out-of-Network Dentists. Some Out-of-Network Dentists will file the claim as a courtesy to their patients, but they are under no obligation to do so. A Covered Person must submit such claims to the TPA within 12 months of the date of service. A Covered Person must give the TPA all of the information the Plan needs to process such claims, including an ADA approved claim form, an invoice of the charges and proof of payment. If a Covered Person does not provide this information, a Covered Person may not be paid. The Plan will not make any payment if the request and proof of service is submitted to the TPA more than 12 months after the date of service. However, these limits will not apply while a Covered Person lacks legal capacity.

The Plan will pay all Covered Expenses to the Covered Employee provided that documentation of payment is included with the claim form. With written authorization from the Covered Employee or Covered Person, all or a portion of the Covered Expenses due may be paid directly to the Out-of-Network Dentist. A Covered Person is responsible for the Deductible and any out-of-pocket expenses required by the Plan including the cost of expenses that are not covered by the Plan.

Filing a Claim for Out-of-Network Dentist Expenses
Submit the claim to the Plan's TPA as indicated in the General Information of this booklet. Be sure a Covered Person's claim includes the following information:

(a) The Covered Employee's name and address;
(b) Patient's name, date of birth, identification number
(c) Name and address of the Provider of services;
(d) Diagnosis from the Dentist;
(e) Itemized bill which gives an ADA code, or description of each charge;
(f) ADA Claim form, including date of service; and
(g) Rendering Dentist's Tax ID number (W-9 form)

Note: Some claims may require more information, such as a radiograph image or a periodontal chart before being processed. Benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing. Reference the Plan General Exclusions, Limitations and Restrictions, including provider supporting documentation provision for more information.

Incurred Expense Date
The completion date for multi-stage procedures including, fixed prosthodontic treatment (bridges and single crowns), will be recognized as the date of service. The date of the final impression will be recognized as the date of service/payment for removable prosthodontic treatment and implant supported prosthetics. The completion date for endodontic treatment will be recognized as the date of service/payment. Unless otherwise specified, the completion of the final treatment will be recognized as the date of service.

CLAIM FILING AND APPEAL PROCEDURES ("PROCEDURES")

The following Procedures explain various rules and time limitations for filing a Claim for benefits under the Plan and additional rules and time limitations for filing an appeal of a Claim that is wholly or partially denied. For purposes of interpreting these Procedures, refer to the Definitions section of this booklet for a listing of terms as they appear herein:

Claim Filing and Notice Requirements
In-Network Dentists are required to file all claims on behalf of a Covered Person. Out-of-Network Dentists are not obligated to file a claim, but many will do so as a courtesy for their patient. All Claims must be filed with the Plan's Third-Party Administrator identified on the General Information page found within this booklet. All Claims for payment of benefits must be filed with the Third-Party Administrator within twelve (12) months of the date of service.

For any Claim which does not provide information necessary for the Third-Party Administrator to make the determination, the Claimant will be notified that additional information is needed within fourteen (14) days via an Explanation of Benefits (EOB). After receiving notification, the Claimant must provide the missing information within forty-five (45) days for post-service claims. Failure to provide the missing information within the required time deadline may result in the denial of the Claim.

If a Covered Person's Claim for benefits is wholly or partially denied, any notice of such adverse benefit determination under the Plan will be communicated on an explanation of benefits (EOB).

Appeal Procedures
If a Covered Person's Claim for benefits is wholly or partially denied, any notice of such adverse benefit determination under the Plan will be communicated on an explanation of benefits (EOB). In the event a Claim is wholly or partially denied, the Claimant has the right to appeal to the Plan Administrator of the Plan for review of the Claim. Unless otherwise specified, all appeals will be decided by the Plan Administrator, identified on the General Information page found within this booklet.

All Claims which are wholly or partially denied may be appealed pursuant to the Procedures set forth below. All appeals must be filed within 90 days of the date that the Claim was totally or partially denied. Failure to file an appeal of a Claim

within the foregoing time deadline will result in the initial Claim decision becoming final and binding on all parties and will be deemed to void any right the Claimant may have to seek judicial review of the original Claim denial.

The Plan Administrator shall review the initial determination and make a decision on any appeal of a Claim within 30 days of receiving the request.

Any Covered Person making an appeal will have the opportunity to submit written comments, documents or other information in support of the appeal. Additionally, any Covered Person filing an appeal will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information whether or not presented or available at the initial determination. No deference will be afforded to the initial determination. In the case of an appeal of a Claim denied or partially denied based on medical judgment, the Plan Administrator will consult with a professional with the appropriate training and expertise. The health care professional who is consulted on appeal will not be the same individual who may have been consulted during the initial determination. If the advice of a dental expert was obtained by the Plan in connection with the denial of the Claim, the names of each such expert shall be provided upon request. This administrative appeal process must be completed before any legal action regarding the Claim can be taken. Additionally, if any such judicial proceedings are undertaken, the evidence presented shall be strictly limited to the evidence presented to the Plan Administrator pursuant to the Appeal Procedures.

Coordination of Benefits

This Coordination of Benefits provision applies when the Covered Person entitled to dental benefits for Covered Expenses under the Plan is also covered by another plan or plans of dental care benefits. This provision applies whether or not a claim is filed under the other plan or plans. If required by the Plan Administrator, authorization shall be given to the Plan Administrator by the Covered Employee or other appropriate person to obtain information concerning benefits or services available from the other plan or plans, or to recover overpayments.

A. "Plan" as used in this provision will include the Plan and any other plan providing benefits or services for dental treatment when such benefits or services are provided by:
   1. Group insurance or any other arrangement of coverage for persons in a group whether on an insured, partially insured or uninsured basis;
   2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;
   3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
   4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;
   5. Any coverage under a Governmental program, and any coverage required or provided by any statute;
   6. Group automobile insurance;
   7. Individual automobile insurance coverage on an automobile leased or owned by the Employer; or
   8. Individual automobile insurance coverage based upon the principles of "No Fault" coverage.

   The term "Plan" in this provision will be construed separately herein with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

B. "Claim Determination Period" means a Plan Year or that portion of a Plan Year during which the Covered Person for whom claim is made has been covered under the Plan.

Coordination Procedures

Notwithstanding other provisions of the Plan, benefits that would otherwise be payable under the Plan will be reduced so that the sum of the benefits payable for Covered Expenses incurred during any Claim Determination Period under:

A. All plans required to pay before the Plan; and
B. The Plan will not exceed the lesser of the allowable expenses under the primary or secondary plan.

Payments

Each plan will make its benefit payment according to where it falls in the following order.

A. A plan which contains no provision for coordination of benefits pays before all other plans.

B. A health care plan sponsored by, or provided through, a school or other educational institution pays before any other plans with a provision for coordination of benefits.

C. A plan which provides coverage to the claimant by virtue of current employment pays before a plan which provides coverage to the claimant by virtue of past or inactive employment. Within each category of plans, the following rules apply:

1. The plan which covers the claimant as an employee (or named insured) pays before a plan which covers the claimant as a dependent.
2. The plan which covers the claimant, other than a child whose parents are separated or divorced, as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a Calendar Year will be paid prior to the benefits of a plan which covers such claimant as a dependent of another person with a birthday later in a Calendar Year. If the other plan does not contain a provision similar to this item 2. which results in the inability to determine priority of benefits, the provisions of this item 2. shall apply, and the rule set forth in this Coordination Procedures provision shall determine the order of benefits.
3. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one Plan the order of benefits is determined as follows:

For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:

- If a court decree states that one of the parents is responsible for the Dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
- If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
- If there is no court decree allocating responsibility for the Dependent Child's health care expenses or health care coverage, the order of benefits for the child are as follows:
  i. The Plan covering the Custodial parent;
  ii. The Plan covering the spouse of the Custodial parent;
  iii. The Plan covering the non-custodial parent; and then
  iv. The Plan covering the spouse of the non-custodial parent.

To the extent the above rules do not establish the order of benefit determination, the benefits of the plan which has covered the claimant for the longer period of time immediately prior to the incurred date of the claim shall be determined first.

Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a. can determine the order of benefits.

COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan.

The Plan Administrator has the right:

A. To require that the claimant provide the Plan Administrator with information on such other plans so that this provision may be implemented; and
B. To pay the amount due under the Plan to another insurer or other organization if this is necessary, in the Plan Administrator's opinion, to satisfy the terms of this provision.

GENERAL PROVISIONS

Use and Disclosure of Protected Health Information
The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations.

The Plan will not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual. The Employer agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan or as required by law. PHI shall not be used for marketing or fundraising, and shall not be sold;
- Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided of which it becomes aware. Any authorized breach will be reported to affected individuals;
- Make PHI available to an individual in accordance with HIPAA's access requirements, including in the format it is held;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
- If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosures to those purposes that make the return or destruction infeasible).

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

A. The benefits manager;
B. Staff designated by the benefits manager; and
C. The Privacy and Security Officials;

These employees may only have access to and use and disclose PHI for plan administration functions that the Employer performs for the Plan. If these employees do not comply with the provisions of the Plan document, the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

Payment includes activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of Plan benefits or to provide reimbursement for the provision of health care that relates to an individual to whom health care is provided.

These activities include, but are not limited to, the following:

A. Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and Benefit Percentage as determined for an individual's claim);
B. Coordination of benefits;
C. Adjudication of health benefit claims (including appeals and other payment disputes);

D. Establishing employee contributions and COBRA premiums;
E. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
F. Billing, collection activities and related health care data processing;
G. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
H. Medical necessity reviews or review of health care services for coverage under the plan, appropriateness of care or justification of charges;
I. Utilization review, including precertification, preauthorization, concurrent review and retrospective review;
J. Disclosing the following information to consumer reporting agencies related to the collection of premiums or reimbursement: name, address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
K. Reimbursement to the Plan.

Health Care Operations

A. Quality assessment and improvement activities;
B. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions that do not include treatment;
C. Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
D. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
E. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
F. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including, but not limited to, formulary development and administration, development or improvement of payment methods or coverage policies;
G. Business management and general administrative activities of the Plan, including, but not limited to: (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, (b) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers, (c) resolution of internal grievances, and (d) the sale, transfer, merger or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
H. Creating de-identified health information or a limited data set.

Security of Electronic Protected Health Information.
The Plan Administrator has adopted procedures to comply with the electronic security rules. The procedures permit the Employer to receive electronic PHI in accordance with the requirements of the electronic security rules. As the sponsor of the Plan, the Employer will implement administrative, physical, and technical safeguards that reasonably and appropriated protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan, as required by the electronic security rules. To ensure adequate separation between the Employer and the Plan the Employer will develop, implement and maintain reasonable and appropriate security measures. The Employer will ensure that any agent, including any subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect the electronic PHI. The Employer will report to the Plan any security incident or breach of which it becomes aware.

Payment of Claims
Plan benefits will be paid to the In-Network Dentist or, if the Out of Network Dentist refuses to file the claim on behalf of the Covered Person and the Covered Person submits the appropriate proof of claim and proof of payment, the Plan benefits will be reimbursed to the Covered Employee. However, if any such benefit remains unpaid at the death of the Covered Employee or if the Covered Person is a minor or is, in the opinion of the Plan Administrator, legally incapable of giving a valid receipt and discharge for any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Covered Employee: wife, husband, mother, father, child or children, brother or brothers, sister or sisters. Any payment so made will constitute a complete discharge of the obligation to the extent of such payment, and the Plan Administrator will not be required to oversee the proper application of the money so paid.

Facility of Payment
Whenever payments which should have been made under the Plan in accordance with this provision have been made under any other plan or plans, the Plan Administrator will have the right, exercisable alone and at its discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision. The amounts so paid will be deemed to be benefits paid under the Plan and to the extent of such payments; the Plan Administrator will be fully discharged from liability under the Plan. The benefits that are payable in accordance with this provision will be charged against any applicable maximum payment or benefit of the Plan rather than the amount payable in the absence of this provision.

Rights of Recovery
Whenever payments have been made in excess of the amount due under the Plan, the Plan Administrator shall have the right, exercisable alone and in its sole discretion, to recover such excess payments.

Conformity with Law
If any provision of the Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

Statements
In the absence of fraud, all statements made by a Covered Person will be deemed representations not warranties. No such representations will be used to void coverage or be used in defense to a claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such Covered Person.

Miscellaneous
Section titles are for convenience of reference only and are not to be considered in interpreting the Plan. No failure to enforce any provision of the Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of the Plan.

Future of the Plan
The Plan Administrator, as listed on the General Information page found within this booklet, expects and intends to continue this Plan indefinitely. However, the Plan Administrator reserves the right to amend or terminate the Plan at any time and for any reason. In no event will you become entitled to any vested rights under this Plan. If the Plan is amended or terminated, you and your Dependents may not receive benefits as described in other sections of this booklet. You may be entitled to receive different benefits, or benefits under different conditions. However, it is possible that you will lose all benefit coverage.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction
The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage is available to a Covered Employee who would otherwise lose coverage under the Plan. It can also become available to Covered Dependents under the Plan when they would otherwise lose their coverage under the Plan. An interested person can review the COBRA Procedures for additional information.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “Qualifying Event”. Specific Qualifying Events are listed below. After a Qualifying Event, COBRA continuation coverage will be offered to each person who is a “Qualified Beneficiary”. Each Covered Person could become a Qualified Beneficiary if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage – there is no Employer subsidy.

A Covered Employee will become a Qualified Beneficiary if coverage under the Plan ends as a result of either of the following Qualifying Events:

- Hours of employment are reduced, or
- Employment ends for any reason other than gross misconduct by the Covered Employee.

A covered spouse will become a Qualified Beneficiary if coverage under the Plan ends as a result of any of the following Qualifying Events:

- The Covered Employee dies;

- The Covered Employee's hours of employment are reduced;
- Employment of the Covered Employee ends for any reason other than gross misconduct by the Covered Employee;
- The Covered Employee is entitled to Medicare benefits (under Part A, Part B, or both); or
- The Covered Employee is divorced or legally separated from their covered spouse.

A covered child will become a Qualified Beneficiary if coverage under the Plan ends as a result of any of the following Qualifying Events:

- The Covered Employee dies;
- The Covered Employee's hours of employment are reduced;
- Employment of the Covered Employee ends for any reason other than gross misconduct by the Covered Employee;
- The Covered Employee is entitled to Medicare benefits (Part A, Part B, or both);
- The Covered Employee is divorced or legally separated from their spouse; or
- The covered child is no longer eligible for coverage under the Plan as a Dependent.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a Qualified Beneficiary with respect to the bankruptcy. Covered Dependents will also become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Trade Adjustment Assistance Reform Act of 2002 (the "Trade Act") created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) "eligible individuals". Under the new tax provision, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. Any questions about these new tax provisions can be directed to the Health Coverage Tax Credit Customer Contact Center toll-free at: 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the COBRA Coordinator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or reduction of hours of employment, death of the Covered Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the Covered Employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer will notify the Plan Administrator of the Qualifying Event.

The Covered Employee or Covered Dependent Must Give Notice of Some Qualifying Events

For the other Qualifying Events (divorce or legal separation of the Covered Employee or a Dependent child losing coverage under the Plan as a Covered Dependent), the Covered Employee or Dependent must notify the COBRA Coordinator within 60 days (review the COBRA Procedures in your SPD for specific rules) after the Qualifying Event occurs. You must provide this notice to the Plan's COBRA Coordinator indicated on the General Information page found within this booklet.

How is COBRA Coverage Provided?

After the COBRA Coordinator receives notice that a Qualifying Event has occurred, an opportunity to elect COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. A Covered Employee may elect COBRA continuation coverage on behalf of their spouse who is a Qualified Beneficiary, and either the Covered Employee or their spouse may elect COBRA continuation coverage on behalf of their children who are Qualified Beneficiaries.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the Covered Employee, the Covered Employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the divorce or legal separation of the Covered Employee, or a Dependent child's losing eligibility as a Covered Dependent, COBRA continuation coverage lasts for up to a total of 36 months. When the Qualifying Event is the end of employment or reduction of the Covered Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of continuation coverage
If a Covered Person is determined by the Social Security Administration to be disabled and the COBRA Coordinator is notified in a timely fashion, each Covered Person may be entitled to receive up to an additional 11 months of COBRA continuation coverage (while the disability continues), for a total maximum of 29 months. The disability must have started before the 60th day of COBRA continuation coverage, must last at least until the end of the 18-month period of continuation coverage and must continue during the disability extension. An interested person can review the COBRA Procedures for additional rules.

Second qualifying event extension of 18 month period of continuation coverage
If a Covered Person experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, each Covered Dependent (but not the Covered Employee) can get up to 18 months additional months of COBRA continuation coverage, for a maximum of 36 months, if timely notice of the second Qualifying Event is properly given to the Plan's COBRA Coordinator within 60 days of the second event. This extension may be available to each Covered Dependent receiving continuation coverage if the Covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or available to a Covered Dependent if the Covered Dependent stops being eligible under the Plan as a Dependent. This extension is available only if the event would have caused the Dependent to lose coverage under the Plan had the first Qualifying Event not occurred.

Questions
Questions concerning the Plan or COBRA continuation coverage should be addressed to the COBRA Coordinator. For more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes
In order to protect rights under the Plan, the Covered Employee should keep the COBRA Coordinator informed of any change in the mailing address for the Covered Employee or a Covered Dependent. The Covered Employee should also keep a copy of any notices sent to the COBRA Coordinator.

COBRA Coordinator
The Plan's COBRA Coordinator is indicated on the General Information page found within this booklet.

COBRA PROCEDURES

A. Qualifying Event Involving Divorce or Loss of Dependent Status

1. Notification to Plan

Qualified Beneficiaries who lose coverage (or will lose coverage) because of a divorce or legal separation or because a Dependent no longer qualifies as a Dependent (defined in the Plan), must notify the Plan in writing, via either facsimile or U.S. Mail within 60 days after the date of the divorce or loss of Dependent status. Such notice must be sent to the Plan's COBRA Coordinator indicated on the General Information page found within this booklet.

Notice may be made by the employee/former employee or a spouse or Dependent of the former employee. Such notice may be given before the occurrence of the divorce or loss of Dependent status, but must, in all cases, be given no later than sixty (60) days after the date of the divorce or the loss of Dependent status. Oral notice or notice by e-mail is not sufficient under these Procedures.

2. Documents Required for Divorce/Separation

When divorce or legal separation is the Qualifying Event, the Qualified Beneficiary must provide the Plan with a copy of the Court Decree dissolving the marriage. If the divorce or legal separation has not yet been concluded, the Qualified Beneficiary must provide the Plan with any court documents that have been filed (such as Petition for Dissolution) and indicate the date that the divorce or legal separation is expected to be final.

3. Documents Required for Loss of Dependent Status

When loss of Dependent status is the qualifying event, the Qualified Beneficiary must provide information to the Plan to allow calculation of the termination date for coverage.

B. Qualifying Event Involving Termination, Reduction in Hours, Death and Bankruptcy – Notification by Plan

Qualified Beneficiaries who lose coverage because of a termination, reduction in hours, death or bankruptcy will receive a COBRA election form which permits the employee/former employee (and Dependents) to elect COBRA continuation coverage and indicates the premium for COBRA coverage. The election form will be sent by U.S. Mail, postage pre-paid, to the last known address of the employee/former employee. The last known address shall be deemed to be the most recent address contained in the employee/former employee's personnel file unless the employee, spouse or Dependent promptly notifies the Plan in writing of his or her updated address. In the event the employee/former employee changes address, it is his or her responsibility to notify the Plan of any change in address and the Plan shall not be responsible for notices sent to the wrong address if the more recent address was not provided in the above manner. Notification to an employee/former employee who elected spousal coverage will be sent addressed to both individuals. Election forms sent to an employee/former employee that has one or more children/dependents covered shall be addressed to the employee (if the spouse was not covered) or to the employee and spouse (if spousal coverage was elected), and each shall be deemed to include notification to any Dependent children, unless the Plan has actual knowledge of a different address for a Dependent child before the date the election form is mailed and provided further that any such notification to the Plan was in writing via either U.S. Mail or facsimile.

C. Errant Notices

In the event an individual receives a COBRA election form before the date the Plan determines that the individual is not eligible to elect COBRA (either because of an error concerning the individual's eligibility or because the individual was fired for gross misconduct), the Plan will notify the individual that they are not eligible for COBRA coverage via U.S. Mail. In the event that an individual receives a COBRA election form with incorrect plan information, the Plan will notify the individual of the accurate terms and the election option will reflect plan benefits and coverage as is correct.

D. Early Termination of COBRA

In the event a Qualified Beneficiary's COBRA coverage terminates before the maximum permitted duration of COBRA coverage (either 18, 29, or 36 months for a particular Qualifying Event(s)), the Plan will notify the Qualified Beneficiary of the early termination date and the reason for early termination of COBRA coverage.

E. Postmark Date

All notifications, payments and other correspondence from a qualified beneficiary (or a possible qualified beneficiary) shall be deemed to have been received on the date that the item is postmarked, if sent by U.S. Mail. In the event communication or correspondence is sent via facsimile, the communication or correspondence shall be deemed to have been received on the date it is transmitted. All correspondence must be sent to the COBRA Coordinator identified in paragraph A. above.

F. Eleventh Month Disability Extension

Qualified Beneficiaries who timely elect COBRA and who are determined by Social Security to be disabled within the first 60 days of COBRA continuation coverage (or earlier) may elect to extend the 18 month COBRA period by up to eleven (11) months (or as long as the disability continues). The eleven month extension will only be given if the Plan is notified in writing, via either U.S. Mail or facsimile, of the Social Security determination. This written notification must also contain a copy of the Social Security determination. Qualified Beneficiaries are required to request the eleven (11) month extension within 30 days of receiving the Social Security determination and, in any event, the Plan must receive the Social Security determination before the end of the 18-month COBRA continuation period. Any Qualified Beneficiary not meeting each of these rules will not be entitled to elect the eleven (11) month extension.

Qualified Beneficiaries who were originally determined to be disabled but whose determination was reversed must notify the Plan within 30 days of notification of the reversal. In the event the Qualified Beneficiary does not notify

the Plan of any such reversal, the Qualified Beneficiary shall be required to repay the Plan for any claims which were incurred after the date of reversal.

G. Multiple Qualifying Events

If a Qualified Beneficiary experiences a second Qualifying Event during the original 18 or 29 month period and wishes to apply for an extension of the 18 or 29 months because of the second Qualifying Event, he or she must notify the Plan's COBRA Coordinator via either U.S. Mail or facsimile within 60 days after the second Qualifying Event occurs. Any Qualified Beneficiary who fails to notify the Plan's COBRA Coordinator of the occurrence of the second Qualifying Event will not be entitled to extend coverage past the end of the 18 or 29 month period. COBRA coverage shall not extend beyond 36 months from the day of the original Qualifying Event, regardless of the occurrence of multiple Qualifying Events. Whether the subsequent Qualifying Event entitles a Qualified Beneficiary to extend coverage, under the applicable regulations, will be determined by the Plan.

H. Payment Requirements

COBRA payments must be paid monthly in the amount designated on the Election Form. The first COBRA payment is due within forty-five (45) days after the election form is executed. This payment covers the cost of the dental coverage provided from the date of the qualifying event (or loss of coverage, if later) through the date of the election. After the first payment, all subsequent COBRA payments are due on the first of each month for the applicable month. If a monthly premium is not paid by its due date, the qualified beneficiary may pay the premium within a thirty (30) day grace period beginning on the due date for the premium. When the premium is not paid prior to the end of the grace period, COBRA coverage will terminate at the end of the period for which the last premium was paid.

All payments of COBRA premiums should be made by check, money order or cashier's check. If payment is made by personal check, the qualified beneficiary shall be solely responsible for maintaining sufficient funds in his/her account so that the check will clear when presented. If a COBRA payment paid by personal check does not clear when first presented, the Plan shall make a second attempt to cash the check if the Plan has at least five (5) working days' notice before the end of the thirty (30) day grace period. It is the obligation of the qualified beneficiary to confirm that his/her COBRA personal checks have cleared the bank. The Plan shall not be under any obligation to notify the qualified beneficiary if a check does not clear. Additionally, if the Plan is presented with a personal check that does not clear, the Plan shall have the option of requiring all subsequent COBRA payments to be made by guaranteed funds (i.e. money order or cashier's check).

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Statement of ERISA Rights
All individuals eligible to participate in the Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all such individuals shall be entitled to:

1. Examine, without charge, at the Employer's office and at other specified locations, such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Employer. The Employer may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Employer is required by law to furnish each Covered Employee with a copy of this summary annual report.
4. In addition to creating rights for Covered Persons, ERISA imposes duties upon those who are responsible for the operation of the Plan. Those who operate the Plan, called "fiduciaries of the Plan", have a duty to do so prudently and in the interest of the Covered Persons. A Covered Person cannot be discriminated against in order to prevent such Covered Person from obtaining a welfare benefit or any other right imposed by ERISA. If a Covered Person is denied in whole or in part, the Covered Person has the right to have the Employer review and reconsider the claim. Under ERISA, a Covered Person must receive requested documents from the Employer within thirty (30) days after a written request for them, or the Covered Person may file suit in Federal Court. In such a case, the court may require the Employer to provide the materials and pay the Covered Person up to $110 a day until receiving the materials, unless the materials were delayed due to reasons beyond the control of the Employer. If a Covered Person's claim for benefits is denied in whole or in

part, he or she may file suit in a State or Federal Court. If the Plan's fiduciaries misuse the Plan's money or if a Covered Person is discriminated against due to filing for a claim, such Covered Person may seek assistance from the U.S. Department of Labor or may file suit in a Federal Court. The Court will decide who should pay court costs and legal fees. Any questions about this statement or about a Covered Person's rights under ERISA should be addressed to the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The website is www.dol.gov/ebsa.

Plan Administrator's Right to Construe and Interpret Plan
The Plan documents confer upon the Plan Administrator the authority and discretion to construe and interpret the terms of the Plan and determine eligibility for benefits.

Time Limitation for Filing Individual Action.
Subject to the other limitations contained in the section of this booklet entitled Claim Filing and Appeal Procedures, in no event may any Covered Person file a lawsuit seeking payment of wholly or partially denied Claims more than one year after the Claim is initially denied, or, if later, more than six (6) months after the date the Appeal decision of the Plan Administrator is rendered.

DEFINITIONS

Certain words and phrases listed in the booklet are defined below. Any term not listed shall be understood by its normal meaning within the context in which it is used. Masculine pronouns used in this booklet shall include both the masculine and feminine gender unless the context indicates otherwise. Words used in this booklet in the singular or plural shall also be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

Benefit Percentage means that portion of Allowable Expenses in excess of the Deductible to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any out of pocket expenses in excess of the Deductible which are to be paid by the Covered Employee.

Calendar Year means a period of time commencing on January 1 and ending on December 31 of the same given year.

Claim means a request for a specific dental treatment, for coverage of a treatment which has already been rendered, or a request for payment of benefits for dental services provided. For purposes of these Procedures, the following are not considered a "Claim":

- Any interaction between a Claimant and a dentist, if the dental provider exercises no discretion on behalf of the Plan.
- Any reply to a request for a pre-certification which does not deny coverage (or limit coverage) for dental services
- A dental provider's refusal to render services without payment by the Claimant
- Casual inquiries about benefits or the circumstances under which benefits might be paid

Claimant means any Covered Person filing a claim under the Plan pursuant to these Procedures.

Close Relative means the spouse, parent, brother, sister, child, or spouse's parent of the Covered Person.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

Cosmetic Procedure means a dental procedure performed for the purpose of changing or altering the appearance of the body for any reason whether medically necessary or not.

Covered Dependent means a Dependent of a Covered Employee meeting the requirements for coverage as specified in this Summary Plan Description while such Dependent remains properly enrolled for coverage in accordance with the provisions of this Summary Plan Description.

Covered Employee means an Employee of the Employer meeting the requirements for coverage as specified in this Summary Plan Description while such Employee remains properly enrolled for coverage in accordance with the provisions of this Summary Plan Description.

Covered Expense / Maximum Allowable Expense means the portion of a charge, incurred by a Covered Person, for dental treatment, services or supplies, which is payable, subject to the Deductible and Benefit Percentages, as a benefit in accordance with the terms and conditions of this Plan or any other Plan providing benefits or services for dental treatment that:

A. for In-Network Benefits, equals the lesser of:
   1) The payment amount the Dentist has agreed to accept pursuant to a contract with Health Resources, Inc.;
   2) The payment amount Paramount Dental has negotiated with the Dentist; or
   3) The Dentist's eligible billed charge if lower than the reasonable and customary charge.
   4) The allowable amount the Dentist has agreed to accept pursuant to a contract with an enrollee's primary insurance carrier as it relates to network participation and coordination of benefits.

B. for Out-of-Network Benefits, does not exceed either:
   1) The table of allowances; or
   2) The Dentist's eligible billed charge.
   3) The allowable amount the Dentist has agreed to accept pursuant to a contract with an enrollee's primary insurance carrier as it relates to network participation and coordination of benefits. (allowable, negotiated, contracted amount)

Covered Person means a Covered Employee or a Covered Dependent.

Covered Service means dental procedures, treatments, supplies subject to a general exclusions, limitations, and restrictions provision as disclosed in the Schedule of Benefits.

Deductible means a specified dollar amount of Covered Expenses not payable under the Plan which must be incurred in each Deductible Accumulation Period before Covered Expenses in excess of such amount can be considered for payment at the Benefit Percentage.

Deductible Accumulation Period means the period of time during which Covered Expenses equal to the Deductible must be incurred before Covered Expenses incurred by the Covered Person during the period in excess of the Deductible can be considered for payment at the Benefit Percentage.

Dentist means any doctor who is duly licensed and qualified to provide dental services or oral surgery under the law of the jurisdiction in which treatment is received.

Dependent Coverage means eligibility under the terms of the Plan for benefits payable as a consequence of Covered Expenses incurred by a Covered Dependent.

Electronic Notification means the transmission of Claim for dental information via the internet, or fax.

Employee means a person retained for Full Time or Part-Time Employment by the Employer.

Employer means Southern Indiana School Trust

Enrolled means the Employee has requested coverage for himself and any dependent, if eligible for dependent coverage, by completing the enrollment form, provided the Plan with any required information and the person has been approved for coverage by the Plan.

ERISA refers to the Employee Retirement Income Security Act of 1974, as amended from time to time.

Family means a Covered Employee and his Covered Dependents.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Incurred Expense means the charge for a dental treatment, service or supply rendered to a Covered Person.

Injury means a bodily condition which results directly from an accident and independently of all other causes.

In-Network Benefits means dental services rendered by a Participating, In-Network, Par Provider.

Under Out-of-Network Benefits, if a portion of a Dentist's charge exceeds the table of allowances, that amount is not considered an eligible expense and is a Covered Person's sole responsibility. You may request a pre-treatment estimate for information about the table of allowances and payment responsibility for charges under Out-of-Network Benefits.

Out-of-Network Benefits means dental services rendered by a non-Participating, non-Par, Out-of-Network Provider.

Participating Provider (In-Network / Par Provider) means a Dentist who has entered into an agreement with Paramount Dental to provide services to a Covered Person. Paramount Dental reserves the right to make changes in the Participating Provider network that they believe is appropriate or necessary.

Plan means the terms and conditions of the dental benefit plan described in this Summary Plan Description.

Plan Year means, for the first year, the period commencing on the Plan Effective Date and ending on the last day of the month preceding the date twelve months subsequent to the Plan Effective Date. Each subsequent Plan Year is the twelve month period commencing at the end of the previous Plan Year.

Pre-Service Claim means a Claim for dental care, when the Covered Person may be required to obtain pre-authorization the treatment is rendered in order for the Plan to consider available benefits.

Post-Service Claim means a Claim submitted after the services have been rendered.

Special Enrollment Period means a thirty (30) day period during which a person, who declined coverage under the Plan when eligible, becomes eligible again to enroll for coverage under the Plan.

Third Party Administrator (TPA) means the entity that has been contracted by the Plan Administrator to perform certain administrative functions on behalf of the Plan Administrator with respect to the benefits provided under the Plan. Such functions may include the issuance of benefit summaries, basic record keeping and reporting, and the processing of claims.

Wage or Salary means the compensation from which federal withholding is applicable.