Gustavus Adolphus College

Dental Coverage
Gustavus Adolphus College - #399
Employee Dental Benefit Plan

Amendment #2

Effective June 1, 2011, the Gustavus Adolphus College Employee Dental Benefit Plan is hereby amended as follows:

1. Under Dental Benefit Summary, the section titled Preventive Services has been deleted and replaced with the following:

<table>
<thead>
<tr>
<th>Dental Benefit Summary</th>
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<tr>
<td><strong>PREVENTIVE SERVICES</strong></td>
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<tr>
<td>• Oral Exams and Cleanings – two times per Calendar Year</td>
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<td>▲ bitewing x-rays, two sets per Calendar Year</td>
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<tr>
<td>▲ full mouth set of x-rays including panograph (one panograph in any three year period)</td>
</tr>
<tr>
<td>• Sealants on permanent teeth (Dependent children under age 19) - once in a three year period</td>
</tr>
</tbody>
</table>

2. Under Definitions, the section titled Dependent has been deleted and replaced with the following:

**Dependent** - A properly enrolled person who is an Employee’s lawful spouse or same-sex Domestic Partner (as defined in the Gustavus Adolphus College Domestic Partner Policy), or a child under age 26 if the child meets the requirements listed below. Children include:

1) Natural or legally adopted Children;

2) Step-children if:
   a) they have a permanent parent-child relationship with you.

3) Children of an Employee’s Domestic Partner if:
   a) they meet the definition of “eligible child” established by the Internal Revenue Code Sections 151 and 152 (i.e. son, daughter, grandchild, step-child, adopted child or legal ward).

4) Other children if:
   a) you are a legal guardian of the child(ren), or other children if they are the natural child of a covered Dependent.

Coverage can be continued beyond the limited age for a dependent child who is incapable of self support because of a Developmental Disability or physical handicap. Application for continuing coverage must be made within 31 days of the child attaining the limiting age. Coverage will continue as long as the child continues to be incapable of self sustaining employment and remains primarily dependent on you. The term “Dependent” does not include any Dependent who is on active duty in a military service, except for temporary active duty of 31 days of less.
3. Under Eligibility and Effective Dates, the section titled Participant Requirement has been deleted.

4. Under Schedule of Benefits – Preventive, the bullets for Space Maintainers and Sealants have been deleted and replaced with the following:

   Preventive
   - Sealants on permanent teeth for eligible Dependent children under 19 years of age, once in a three year period
   - Space maintainers for eligible Dependent children under 19 years of age

5. Under Termination of Coverage, the 4th bullet in the section titled Dependent Coverage Termination has been deleted.
Effective June 1, 2010, the Gustavus Adolphus College Employee Dental Benefit Plan is hereby amended as follows:

1. Under Dental Benefit Summary, the section titled Major Restorative has been deleted and replaced with the following:

   **Dental Benefit Summary**
   
   **MAJOR RESTORATIVE**
   
   • Crowns (other than stainless steel)
   • Gold Fillings
   • Inlays & Onlays
   • Implants

2. Under Schedule of Benefits – Major Restorative, the bullet for Implants has been added as follows:

   **Major Restorative**
   
   • Implants

3. Under Limitations and Exclusions, the bullet for Implants has been deleted.

4. Under Termination of Coverage, the 4th bullet in the section titled Dependent Coverage Termination has been deleted and replaced with the following:

   • At midnight on the last day of the month during which the Dependent ceases full-time school attendance except that:

   ▲ If cessation is due to school vacation (either summer vacation or semester/quarter chosen by the Dependent during the school year), Dependent status shall terminate on the date the school reconvenes if attendance does not resume; or

   ▲ If cessation is due to a "medically necessary leave of absence" the date that is one year after the first day of the "medically necessary leave of absence". A "medically necessary leave of absence" means a leave of absence from a postsecondary educational institution that commences while such child is suffering from a serious illness or injury, is medically necessary, and causes such child to lose student status for purposes of coverage under the terms of the plan. A serious illness or injury is one that is so severe that it prevents a Dependent child from attending school. Short-term sickness, sprains and strains are not a serious illness or injury.
4. (continued)

Certification by Physician – The requirement to extend coverage during “medically necessary leaves of absence” applies only if the plan receives a written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary. The Certification by Physician must be provided within 30 days of the commencement of the "medically necessary leave of absence".
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GENERAL PLAN INFORMATION

Plan Sponsor/Plan Administrator: Gustavus Adolphus College  
800 West College Avenue  
St. Peter, Minnesota 56082  
(507) 933-7304

Name of Plan: Dental Benefit Plan of Gustavus Adolphus College

Group Number: 399

Plan Sponsor Tax ID Number: 41-0695524

Effective Date: June 1, 1997, restated effective June 1, 2009

Plan Year End: May 31

Type of Plan: Group Dental Coverage

Contract Administrator: Sheffield, Olson & McQueen, Inc.  
2145 Ford Parkway, Suite 300  
St. Paul, Minnesota 55116-1912  
(651) 695-2500 or 1-800-486-7664

Agent for Service of Legal Process: Gustavus Adolphus College  
800 West College Avenue  
St. Peter, Minnesota 56082  
(507) 933-7304

Contribution Basis: This Plan provides Contributory coverage for Employees and Dependents.
Purpose of Plan

The purpose of the Plan is to provide certain dental care benefits for eligible Employees of the Employer and their eligible Dependents.

As a member of the Plan, your rights and benefits are determined by the provisions of the Plan. This booklet describes those rights and benefits. It outlines what you must do to be covered. It explains how to file claims. It is your explanation booklet while you are covered.

In addition to the limitations with respect to benefits set forth elsewhere in the Plan, nothing contained herein shall be construed as a guarantee of employment.

PLEASE NOTE: Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, pre-treatment estimates or other cost management requirements, lack of Dental Necessity, lack of timely filing of claims, or lack of coverage. These provisions are explained in this document.

A Covered Person should contact the Contract Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test, or any other aspect of Plan benefits or requirements.

PLEASE READ YOUR BOOKLET CAREFULLY. We suggest that you start with a review of the terms listed in the DEFINITIONS section. Terms which have a special meaning begin with a capital letter and are explained in the DEFINITIONS section.
ADMINISTRATIVE PROVISIONS

Type of Plan

The Plan is a welfare Plan to provide benefits for eligible dental care expenses for covered Employees of the Employer and their Dependents.

Method of Funding

Plan benefits are self-funded and are provided directly from the general assets of the Plan Sponsor. The Plan Sponsor is responsible for the financing and administration of the Plan. A third party administrator provides claims administration. The Plan is not insured.

The Employer may require that Covered Persons contribute toward the cost of providing Plan benefits. The amount of such contributions will be determined by the Employer and may be changed by the Employer from time to time. The Employer will deduct such contributions on a regular basis from the wages or salary of Employees who receive coverage under the Plan.

Type of Administration

This Plan is administered by a Contract Administrator under the terms and conditions of an Administrative Service Agreement between the Plan Sponsor and Contract Administrator.

Incontestability

No statement made by any Covered Person under this Plan relating to themselves or a minor shall be used in contesting the validity of the coverage with respect to which the statement was made, unless it is contained in a written application signed by the person or the guardian of such person if a minor.

Legal Actions

No action at law or in equity shall be brought to recover on the Plan prior to the expiration of 60 days after the written proof of loss has been furnished in accordance with the requirements of the Plan. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Workers' Compensation Coverage

This Plan is not in lieu of and does not affect any coverage required by Workers' Compensation Laws or similar laws.
Amendment, Termination and Administration of Plan

The Plan Sponsor reserves total rights and power to alter and amend or terminate the Plan, at any time within its discretion by adoption of a written amendment containing the new terms of the Plan. The Plan Sponsor has full discretion to determine eligibility of benefits and to construe Plan terms and conditions.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Expenses incurred before termination, amendment or elimination.

Conformity With Governing Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

Independent Contractor Relationship

The relationship between the Employer, the Contract Administrator and, where applicable, the Preferred Provider Network and Preferred Providers are contractual relationships between independent contractors. The relationship between a Covered Person and any provider remains that of patient and health or dental care provider. The provider is solely responsible for any health or dental care provided to a Covered Person.
PROVISION OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

Introduction

With respect to this Plan, certain members of the Company’s workforce have access to the individual identifiable health information of Plan participants for administrative functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information (PHI) and, if it is transmitted by or maintained in electronic media, it is Electronic PHI.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations (the “Privacy Rules”) restrict the Plan Sponsor’s ability to use and disclose PHI. The following HIPAA definition of PHI applies to this plan:

Protected Health Information: Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

Electronic Protected Health Information. Electronic protected health information means Protected Health Information that is transmitted by or maintained in electronic media.

Effective April 14, 2004, the Plan Sponsor shall have access to PHI from the Plan only as permitted under this plan or as otherwise required or permitted by HIPAA and the Privacy Rules.

Permitted Disclosure of Enrollment/Disenrollment Information

The Plan may disclose to the Plan Sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a coverage offered by the Plan.

Permitted Uses and Disclosures of Summary Health Information

The Plan may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (b) modifying, amending, or terminating the Plan.

“Summary Health Information” means: information that (a) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (b) from which the information described at 42 CFR § 164.514(b)(2)(i)(B) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.
Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administrative Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described below and subject to obtaining written certification pursuant to the conditions of disclosure, the Plan may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. “Plan administration purposes” means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI or Electronic PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

Conditions of Disclosure for Plan Administration Purposes

Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan, Plan Sponsor shall:

a. Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

b. Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.

c. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

d. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

e. Make available PHI to comply with HIPAA’s right to access in accordance with 45 CFR § 164.524.

f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526.

g. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

h. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA’s privacy requirements.

i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

j. Ensure that the adequate separation between Plan and Plan Sponsor (i.e., the “firewall”) required in 45 CFR § 164.504(f)(2)(iii), is satisfied.
Adequate Separation between Plan and Plan Sponsor

Plan Sponsor shall allow access to PHI to the Privacy Officer and individuals named by the Privacy Officer. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor’s employee discipline and termination procedures.

Certification of Plan Sponsor

The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(iii), and that the Plan Sponsor agrees to the conditions of disclosure set forth above.
# Dental Benefit Summary

## PREVENTIVE SERVICES
- Oral Exams and Cleanings – two times per Calendar Year
- Fluoride Treatments (Dependent children under age 15) - two times per Calendar Year
- Infection Control
- Space Maintainers (Dependent children under age 12)
- X-Rays
  - bitewing x-rays, two sets per Calendar Year
  - full mouth set of x-rays including panograph (one panograph in any three year period)
- Sealants on permanent teeth (Dependent children under age 14) - once in a three year period

## BASIC RESTORATIVE
- Amalgam (silver), Silicate, Acrylic, or Composite (white) Fillings
- Anesthesia
- Emergency Palliative Treatment
- Extractions
- Endodontics
- General and Local Anesthesia administered with Oral Surgery
- Periodontics
- Stainless Steel Crowns
- Occlusal Guard

## MAJOR RESTORATIVE
- Crowns (other than stainless steel)
- Gold Fillings
- Inlays & Onlays
- **Implants (added effective 6/1/10)**

## PROSTHODONTICS
- Partial or Complete Dentures
- Removable or Fixed Bridgework

Preventive, Basic Restorative, Major Restorative and Prosthodontics is paid as follows:

- First $500 in Covered Expenses per Calendar Year – paid at 100%
- Next $1,000 in Covered Expenses per Calendar Year – paid at 50%

**Calendar Year Maximum Benefit (per Covered Person)** ................................................................. $1,000

## ORTHODONTIA
Orthodontics (covered Dependent children under age 19) ........................................................... 50%
- Braces
- Fixed or Removable Appliances

Orthodontics is paid as follows:

- $2,000 in Covered Expenses per covered Dependent child paid at 50%

**Maximum Lifetime Benefit for Orthodontics (per covered Dependent child)** ............................... $1,000
DEFINITIONS

**Active Employment** - With respect to any eligible Employee, active performance of all customary duties of the Employee’s occupation, at the Employee’s usual place of employment, for the Employer for not less than the following:

- **Faculty** - appointment of 4/6 or greater for the academic year. Faculty members with joint appointments are eligible for the benefits of one Employee under this Plan.
- **Administrators** - appointment to a position that requires 3/4 time or more of a full-time assignment and is budgeted for nine months or longer.
- **Non-contract (support staff)** - appointment to a position that is budgeted for 30 or more hours per week for nine or more months.

An Employee shall be deemed in Active Employment on each day of a regular paid vacation, an Employer approved unpaid professional leave, a regular non-working day, or Employer approved medical leave of absence, provided the Employee was in Active Employment on the last preceding regular working day.

**Annual Enrollment Period** - The period designated by the Employer during which the Employee or Dependent who did not enter the plan when first eligible may enter the Plan. Please see the section titled Eligibility and Effective Date for additional information.

**Benefit Percentage** - The percentage of a Covered Expense which the Plan pays (as shown in the Schedule of Benefits).

**Calendar Year** - The period beginning on January 1st and ending the following December 31st. When a person first becomes covered, the first Calendar Year begins on the Effective Date of coverage.

**Co-insurance** - The percentage of a Covered Expense which the Covered Person is responsible for paying.

**Contract Administrator** - The organization providing administrative services to the Employer in connection with the operation of the Plan and performing such other functions, including processing and payment of claims as may be delegated to it.

**Covered Expense** - A Covered Expense is the Usual and Customary charge by a legally qualified Dentist, or a licensed Dental Hygienist working under the direction of a legally qualified Dentist, for the treatment, material or supplies listed in the Covered Expenses section of this Plan, when necessary and customary as determined by the standards of generally accepted dental practice, to the extent such expense is not excluded or otherwise limited by the Plan.

**Covered Person** - Any eligible Employee, eligible Dependent, Retired Employee and Retired Employee’s spouse (at the time the Retired Employee retires) whose coverage became effective and has not terminated.

**Deductible** - An amount which each Covered Person must contribute toward payment of Covered Expenses as set forth in the Schedule of Benefits.
Dependent - A properly enrolled person who is an Employee’s lawful spouse or same-sex Domestic Partner (as defined in the Gustavus Adolphus College Domestic Partner Policy), an unmarried child under age 19; or an unmarried student age 19, but less than 25 if such child is primarily dependent upon the Employee for financial support and is in full-time school attendance at any accredited, high school, trade school, college or university. Children include:

5) Natural or legally adopted Children;

6) Step-children if:
   a) they have a permanent parent-child relationship with you; and
   b) you pay at least 50% of their support, and
   c) they live with you or are a student as described above.

7) Children of an Employee’s Domestic Partner if:
   a) they are primarily dependent on the Employee for support; and
   b) they live with the Employee in a regular parent child relationship; and
   c) they meet the definition of “eligible child” established by the Internal Revenue Code Sections 151 and 152 (i.e. son, daughter, grandchild, step-child, adopted child or legal ward).

8) Other children if:
   a) you are a legal guardian of the child(ren), or other children if they are the natural child of a covered Dependent; and
   b) you pay 100% of their support; and
   c) they live with you or are a student as described above.

Coverage can be continued beyond the limited age for a dependent child who is incapable of self support because of a Developmental Disability or physical handicap. Application for continuing coverage must be made within 31 days of the child attaining the limiting age. Coverage will continue as long as the child continues to be incapable of self sustaining employment and remains primarily dependent on you. The term “Dependent” does not include any Dependent who is on active duty in a military service, except for temporary active duty of 31 days or less.

Developmental Disability - A child’s substantial disability which results from mental retardation, cerebral palsy, epilepsy or other neurological disorder and is diagnosed by a Physician as a permanent or long term continuing condition.

Disability or Totally Disabled - With reference to an Employee, it is Disability resulting solely from an Illness which prevents an Employee from engaging in any employment or occupation for which he/she is or becomes qualified by reason of education, training, or experience and only when such Employee is, in fact, not engaged in any employment or occupation for wage or profit. For a Dependent, it is Disability which prevents a Dependent from engaging in substantially all the normal activities of a person in good health of like age and sex. A Covered Person must also be under the care of a Physician in order to be Totally Disabled for benefit purposes.

Domestic Partner - An Employee’s same-sex Domestic Partner is a person for whom a signed “Statement of Marriage or Domestic Partnership” has been approved and is on file with Gustavus Adolphus College.

Effective Date of the Plan - The date this Plan is effective with the Contract Administrator.

Employee - A person employed by the Employer. The term Employee shall not include independent contractors or leased Employees.

Employer - The Plan Sponsor as stated in the General Plan Information section of this Plan.
**Fiduciary** - The person or organization that has the authority to control and manage the operation and administration of the Plan. The fiduciary has discretionary authority to determine eligibility for benefits or to construe the terms of the Plan. The named Fiduciary for this Plan is the Employer.

**Late Enrollee** - An Employee or Dependent who enrolls for coverage after their initial Eligibility Date as described under Eligibility and Effective Dates. A Special Enrollee (see Definitions) shall not be considered a Late Enrollee.

**Maximum Lifetime Benefit** - If applicable, means the Maximum Lifetime Benefit payable during an individual’s life while covered under the Plan.

**Plan** - Plan or Employee Benefit Plan means the benefits the Plan Sponsor has agreed to provide for Covered Persons. The term Plan includes this Plan as well as any prior self-funded dental Plans maintained by the Plan Sponsor.

**Plan Sponsor/Plan Administrator** - The person/organization responsible for the day-to-day functions and management of the Plan. The Plan Sponsor may employ persons or firms to process claims and perform other Plan-connected services. The Plan Sponsor is the named Plan Administrator within the meaning of Section 414(g) of the Internal Revenue Code of 1986, as amended.

**Retired Employee** - An Employee who retired from service with this Employer and meets the following criteria:

- at least age 60; and
- has ceased Active Employment and is eligible for retiree coverage; and
- has had a minimum of twenty (20) years or more of satisfactory service for the Employer; and
- was covered under this Plan on the day preceding his or her retirement; and
- agree that coverage for your spouse will be limited to your spouse as of the time you retire; and
- is not covered under another group dental plan as an Employee.

A Retired Employee must enroll in the retiree plan at the first date of eligibility and will not be eligible to join the plan at a future date if he/she opts out at initial date of eligibility. After Enrollment, if at any time the Retired Employee discontinues enrollment in the dental plan, there will be no opportunity for re-enrollment.

**Special Enrollee** - An Employee or Dependent who is entitled to and requests Special Enrollment as described in Special Enrollment Provision under the section titled Eligibility and Effective Dates.

**Special Enrollment** – See heading under the section titled Eligibility and Effective Dates.

**Usual and Customary** - A charge made by a provider of service which does not exceed the general level of charges made by other providers of similar standing rendering or furnishing such services within the area in which the charge is incurred.

The Usual and Customary charge for treatment, material or supplies is the lesser of:

- the charge made by the provider for the services or supplies furnished, or
- the charge most other providers in the same locality would make for those or comparable services or supplies.

**Waiting Period** - Means the period of time that must pass under the Plan before an Employee or Dependent is eligible to enroll in the Plan.
ELIGIBILITY AND EFFECTIVE DATES

Enrollment

Enrollment shall be made on forms provided by the Plan Sponsor or Contract Administrator for such purpose. If Dependents are to be enrolled, Employees enrolled for family coverage must cover all eligible Dependents.

Participant Requirement

If you elect Employee + One or Family dental coverage, you must maintain this coverage for a minimum of two (2) years.

Employee - Eligibility Date

An Employee is eligible to enroll on the date he/she commences Active Employment with the Employer. Coverage will be effective as provided below.

Employee - Effective Date

Eligible Employees who are in Active Employment on the Effective Date of the Plan and who were validly covered under the Employer's plan of coverage which this Plan replaces, will be covered on the Plan's Effective Date. All other Employees will be effective as below:

Employee’s coverage is effective on the first of the month coincident with or following the date of Active Employment.

If Employee coverage is contributory and application is made and received by the Plan Sponsor before, on or within 31 days of completion of the Plan’s Waiting Period, as shown above, coverage will be effective on the Effective Date.

Employee - Late Enrollee

If application is made and received by the Plan Sponsor after 31 days beyond the initial Eligibility Date (other than during a Special Enrollment period available to Special Enrollees), the Employee shall be a Late Enrollee. A Late Enrollee may only enroll for coverage during the Plan’s annual enrollment period as designated by the Employer.

Dependent - Eligibility Date

Dependents of eligible Employees are eligible to be enrolled for coverage on the later of the following dates:

- The date the Employee is effective for coverage under this Plan;
- The date the individual meets the definition of a Dependent, other than a full-time student;
- The first of the month, in the month, during which the Dependent meets the eligibility requirements for full-time student status.
Dependents - Effective Date

Dependents may become covered only if the Employee makes written application for coverage for such Dependents in a form furnished by the Plan Sponsor or Contract Administrator for the purpose (see exception for Newborn/Adopted Children).

Dependent child(ren), of a covered Employee, named in a Qualified Medical Child Support Order shall become covered under the Plan on the date the Qualified Order specifies that coverage shall commence.

If Dependent coverage is contributory and application is made and received by the Plan Sponsor on, before or within 31 days of the Eligibility Date, Dependent(s) coverage shall be effective on the same date the Employee becomes effective for coverage, or on the date the individual meets the definition of Dependent, whichever is later.

Dependent - Late Enrollee

If application is made and received by the Plan Sponsor after 31 days beyond the initial Eligibility Date (other than during a Special Enrollment period available to Special Enrollees), the Dependent, of a Covered Employee, shall be a Late Enrollee. A Late Enrollee may only enroll for coverage during the Plan’s annual enrollment period as designated by the Employer.

Newborn/Adopted Children

A newborn baby will be covered from birth if Employee has family coverage in effect for other family members at the time of birth. An adopted child will be covered from the date of placement if Employee has family coverage in effect on other family members at the time of placement. If family coverage is not in effect, newborn or adopted children must be enrolled within 31 days of birth or placement in order for coverage under the Plan to become effective on the date of birth or placement. After 31 days, the newborn or adopted child(ren) will be considered a Late Enrollee.

Special Enrollment Provision

An eligible Employee or Dependent who waives coverage under the Plan at the time of initial Eligibility (and states in writing at that time that coverage was waived because of alternative health coverage) but subsequently loses coverage under the other health plan and makes application for coverage under this Plan shall be a Special Enrollee provided such person:

1. was under a COBRA (Consolidated Omnibus Budget Reconciliation Act) continuation provision and the coverage under such provision was exhausted; or
2. was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or loss of Dependent status); or
3. lost eligibility for coverage through an HMO, or other arrangement, in the individual market, that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual); or
4. lost eligibility for coverage through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual), and no other benefit package option is available to the individual; or
(5) incurs a claim that would meet or exceed a lifetime limit on all benefits. The Special Enrollment Period continues in the event a claim is incurred or exceeds the lifetime limit until at least 30 days after the earliest date a claim is denied due to the operation of the lifetime limit; or
(6) when a plan no longer offers any benefits to a class of similarly situated individuals; or
(7) was covered under a plan where Employer contributions toward such coverage were terminated; or
(8) was covered under Medicaid or a Children’s Health Insurance Program Plan (CHIP) and coverage is terminated as a result of the loss of eligibility for Medicaid or CHIP coverage; or
(9) becomes eligible for premium assistance to purchase coverage under this Plan under the applicable state Medicaid or CHIP Plan.

Individuals who lose other coverage due to nonpayment of premium or for cause (e.g., filing fraudulent claims) shall not be Special Enrollees hereunder.

An eligible Employee or Dependent who waives coverage under this Plan at the time of initial Eligibility and seeks to enroll in this Plan as a result of the acquisition of a new Dependent through marriage, birth, adoption or placement for adoption shall be a Special Enrollee hereunder if the eligible Employee or Dependent enrolls within thirty-one (31) days of the acquisition of the new Dependent. Coverage will be effective in the event of marriage, the first day of the first calendar month following the date the completed request for enrollment is received by the Plan; or in the event of birth, adoption or placement for adoption, the date of such birth, adoption or placement for adoption.

Coverage for other classes of Special Enrollee shall be effective not later than the first day of the first calendar month following the date the completed request for enrollment is received by the Plan if the eligible Employee or Dependent enrolls within thirty-one (31) days of an event described in (1), (2), (3), (4), (5), (6) and (7); or an Employee or Dependent enrolls within sixty (60) days of an event described in (8) or (9) above.

**Annual Enrollment Period**

Eligible Employees and their Dependents, who did not enroll for coverage when initially eligible, or during a Special Enrollment period, if applicable, will be considered a Late Enrollee. Late Enrollees may enroll for coverage under the Plan once a year during the Plan’s Annual Enrollment Period, as designated by the Employer.

**Qualified Medical Child Support Orders**

Notwithstanding any other Plan provision, upon receipt of a Qualified Medical Child Support Order, the Plan will provide benefits in accordance with Section 609 of ERISA. The Plan Sponsor will establish written procedures for determining (and shall have sole discretion to determine) whether a medical child support order is qualified and for administering the provision of benefits under the Plan pursuant to a Qualified Medical Child Support Order. The Plan Sponsor may seek clarification and modification of the order, up to and including the right to seek a hearing before the court or agency which issued the order.
**Uniformed Services Employment and Reemployment Rights Act**

Notwithstanding any other Plan provision, this Plan will provide benefits in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). With respect to any Employee or Dependent who loses coverage under the Plan during the Employee’s absence from employment by reason of military service, no Pre-existing Condition Limitation or Waiting Period may be imposed upon reinstatement of such Employee’s or Dependent’s coverage upon reemployment of the Employee unless such Pre-existing Condition Limitation or Waiting Period would have otherwise applied to such Employee or Dependent had the Employee not been on military leave of absence.

**Family and Medical Leave Act**

All Plan provisions are intended to be in compliance with the Family and Medical Leave Act of 1993 (FMLA). To the extent the FMLA applies to the Employer, group health benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements, the obligations of the Employer and Employee concerning conditions of leave, and notification and reporting requirements are specified in the FMLA.

**Reinstatement of Coverage**

An Employee’s coverage that has terminated due to termination of employment, lay-off, reduction to part-time status, or Employer approved leave of absence, may be reinstated under the following condition:

(a) The Employee returns to active, full-time employment within six (6) months of the date such termination or leave commenced; and

(b) The Employee re-enrolls for coverage within thirty-one (31) days of the return date to such Active Employment.

The reinstated coverage will be effective on the date the Employee returns to Active Employment. "Reinstatement" means that any previous benefit limitations, maximums or waiting periods applied prior to such termination or leave, will be recognized under the reinstated coverage. In other words, coverage will continue as if no time has elapsed between the termination and reinstatement.

**Dual Coverage**

When a husband and wife are both benefit eligible Employees with this Employer, both husband and wife may elect single coverage through this plan, or one may elect to be covered as a Dependent of the other, but may not also elect single coverage. When a husband and wife are both enrolled for coverage as Employees under this Plan, dependent children can be covered under either Employee's coverage, but not both.

If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his/her covered Dependents will be permitted to immediately enroll under the remaining Employee’s coverage, provided written application is made and received within 31 days of the spouse’s loss of coverage. Such coverage shall be deemed a continuation of prior coverage and any previous benefit limitations, maximums, or waiting periods applied prior to the change in enrollment will be recognized under the replacement coverage.
Pre-Treatment Estimates

A Covered Person may request a pre-determination on any anticipated treatment.

You should ask your Dentist to describe the proposed treatment and charges on a dental claim form. The form should then be sent to Sheffield, Olson & McQueen, Inc. We will review the proposed charges and tell your Dentist how much we will consider as Covered Expenses and how much the Plan will pay.

It is strongly recommended that the Covered Person submit, or have their Dentist submit, a written treatment plan to Sheffield, Olson & McQueen, Inc. in advance of services when treatment is for Major Restorative, Prosthodontics, or Orthodontic services (if covered by the Plan).

A Pre-Treatment Estimate is not a guarantee of payment. Final benefit determination is made upon receipt of claim for actual services rendered, subject to all terms and conditions of the Plan.
SCHEDULE OF BENEFITS

Maximum Benefit

The Maximum Benefit the Plan will pay for all Covered Expenses of a Covered Person during a Calendar Year is $1,000.

The Maximum Lifetime Benefit for Orthodontics is $1,000. Benefits paid for Orthodontic treatment will not reduce the maximum benefits per Calendar Year for other covered dental charges.

COVERED EXPENSES

Preventive

• Dental x-rays:
  ▲ bitewing x-rays, two sets per Calendar Year
  ▲ full mouth set of x-rays including panograph (1 panograph in any three year period)

• Infection Control
  ▲ gloves & disposables
  ▲ sterilization

• Oral examinations, two times per Calendar Year

• Prophylaxis (cleaning of teeth) two times per Calendar Year

• Sealants on permanent teeth for eligible Dependent children under 14 years of age, once in a three year period

• Space maintainers for eligible Dependent children under 12 years of age

• Topical application of fluoride for eligible Dependent children under 15 years of age, two times per Calendar Year
Basic Restorative

- Amalgam (silver), silicate, acrylic, or composite (white) fillings on anterior or posterior teeth
- Drugs or medicines administered or prescribed by a Dentist
- Emergency palliative treatment for relief of pain
- Endodontic treatment, including root canal and pulpotomies, if the tooth is "opened" while insured
- Extractions
- General and local anesthesia when administered with oral surgery
- Oral Surgery
- Injection of antibiotic drugs
- Local anesthesia
- Periodontics, including restorative crown lengthening
- Recementing of the following: crowns, inlays, onlays and bridgework
- Relining of dentures once every two years
- Stainless steel crowns
- Occlusal guard to minimize the effects of bruxism (grinding) or other occlusion problems

Major Restorative

- Crowns (other than stainless steel)
  - However, in order for a replacement crown to be covered, the original crown must be at least five (5) years old.
- Gold fillings
- Inlays
- Onlays
- **Implants (Added effective 6/1/10)**
Prosthodontics

• Initial installation of fixed bridgework including inlays and crowns to replace one or more natural teeth extracted while the individual is covered under this Plan, or extracted while the individual was covered for such extraction under the dental plan replaced by this Plan, if the individual was covered under such plan on the day immediately prior to his or her Effective Date of coverage under this Plan, or to replace one or more congenitally missing teeth.

• Initial installation of partial or full removable dentures (excluding adjustments for the 6 month period following installation) to replace one or more natural teeth extracted while the individual is covered under this Plan or extracted while the individual was covered for such extraction under the dental plan replaced by this Plan, if the individual was covered under such plan on the day immediately prior to his or her Effective Date of coverage under this Plan, or to replace one or more congenitally missing teeth.

• Replacement of existing bridgework by new bridgework, or the addition of teeth on existing bridgework. However, only replacements and additions that meet the "Prosthesis Replacement Rule" will be covered.

• TMJ splints.

• Replacement of an existing partial or full removable denture by a new denture, or the addition of teeth to a partial removable denture. However, only replacements and additions that meet the "Prosthesis Replacement Rule" will be covered.

The "Prosthesis Replacement Rule" requires that replacements or additions to existing dentures or bridgework will be covered only if evidence satisfactory to Sheffield, Olson & McQueen, Inc. is furnished that one of the following applies:

• the replacement or addition of teeth is required to replace one or more teeth extracted while the individual is covered under this Plan, or extracted while the individual was covered for such extraction under the dental plan replaced by this Plan on the day immediately prior to his or her Effective Date of coverage under this Plan, or

• the existing denture or bridgework cannot be made serviceable and was installed at least five (5) years prior to its replacement.

Orthodontics

• Orthodontic retainers (fixed and removable).

• Charges for the repair or replacement of any Orthodontic appliance (fixed or removable) are not included as Covered Expenses.

• Charges in excess of $1,000 are not included as Covered Expenses.

• Benefits are limited to eligible Dependent children under 19 years of age.
LIMITATIONS AND EXCLUSIONS

No benefits will be paid for the following charges:

- Charges not specifically shown as Covered Expenses in the Schedule of Benefits
- Charges for dental procedures performed other than by a licensed Dentist and his or her employees or agents
- Charges for dentistry for cosmetic purposes, including veneers
- Charges for replacement of lost, missing, broken or stolen prosthetic or orthodontic appliances
- Charges for any service, including material and supplies, not incurred and/or completed while the individual is covered for dental benefits under this Plan. A service is considered incurred on the date the service is rendered except:
  - Dentures or Fixed Bridges – Service is considered incurred on the date the impression is taken.
  - Crowns – Service is considered incurred on the date preparation of the tooth begins.
  - Root Canal Therapy – Service is considered incurred on the date work begins on the tooth and the pulp chamber is opened.
- Charges for prosthetic appliances (including but not limited to, bridges and crowns) and the fitting of them, which were ordered while the individual was not covered by this Plan
- Charges for dental services related to temporomandibular joint (TMJ) disorders, as shown on the Schedule of Benefits, that are in excess of the Plan’s Maximum Benefit and that have not been fully coordinated through a medical plan, if applicable
- Charges which would be covered under Workers' Compensation or similar legislation or for conditions resulting while at any occupation for wage or profit

- **Dental Implants and services related to dental implants (Deleted effective 6/1/10)**
- Charges for crown lengthening performed for cosmetic purposes
- Charges for athletic mouthguards
COORDINATION OF BENEFITS

Dental benefits of this Plan are coordinated with benefits of other Plans which provide for payment of dental or medical expenses. The intent is to provide maximum benefit up to 100% of allowable expenses, but no more.

To explain this, a "Plan" is one which covers dental or medical expenses provided by group, franchise, hospital or medical service or other coverage arranged through any association; or any coverage sponsored by or provided through an educational institution. (YOU MUST REPORT ALL MEMBERSHIPS IN GROUP PLANS ON ANY CLAIM YOU SUBMIT.)

A "Plan" also includes any coverage under an automobile insurance policy.

You should file a claim with the 'primary' Plan first. When two or more Plans contain Coordination of Benefits provisions, the primary Plan is:

• the Plan that covers the person claiming benefits as a member or employee, or

• when an individual is covered through two jobs by two Plans, the Plan which covers him as an active Employee or the Plan in effect for the longer period of time, or

• when the claim is for a dependent child of parents who are not separated or divorced, the Plan covering the parent whose birth date occurs earlier in the year. If both parents have the same birth date, the Plan which covered the parent the longest, or

• when the claim is for a dependent child of parents who are separated or divorced:
  ▲ the Plan that covers the parent which the Court has established as the one financially responsible for the health care of the child, or

  ▲ if the Court has not established a parent responsible for the health care of the child, the Plan of the parent having custody pays first, then the Plan of the spouse of the parent with custody pays next, and the Plan of the parent without custody pays last.

If none of the above rules determine the primary carrier, the Plan which covered the patient the longest period of time is the primary carrier.

When this Plan is the primary Plan, it will pay the benefits shown in the Schedule of Benefits.

When this Plan is the secondary Plan, it will pay the remaining balance of Eligible Expenses not paid by the primary Plan. The combined payments will not exceed 100% of Covered Expenses under consideration.
SUBROGATION

In the event of any payment of benefits under this Plan, the Plan shall be subrogated to all of the Covered Person's rights of recovery of those benefits against any person, or organization, either first or third party or, liability or casualty program. The Covered Person shall cooperate with the Plan or the Plan's designated representative and do whatever is necessary to secure those rights, including but not limited to the completion of a Subrogation Agreement if necessary. The Covered Person agrees to do nothing which would prejudice those rights.

It is agreed that if the Covered Person fails to take the necessary legal action to recover from a responsible party, the Plan may proceed in the name of the Covered Person against the responsible party and will be entitled to the recovery of the amount of benefits paid and the expenses for that recovery. In the event the Plan recovers an amount greater than the benefit paid, the excess, reduced by the expenses of recovery, will be paid to the Covered Person. The Plan reserves the right to compromise the amount of its claim if, in its opinion, it is appropriate to do so.
TERMINATION OF COVERAGE

Employee Coverage Termination

An Employee's coverage under this Plan shall terminate, upon the earlier of:

- The date the Plan terminates;
- The date of Employee's entry into the Armed Forces of any country, except for temporary active duty of 31 days or less;
- At midnight on the last day of the month during which the covered Employee leaves or is dismissed from the employment of the Employer or is retired* or pensioned or ceases to be engaged in Active Employment in the conduct of and on the premises of the Employer's business; unless the Employee is on an Employer approved medical leave, which may extend for a period of up to 3 months as determined by the Employer; or the Employee is on an Employer approved leave as may be provided for by the federal Family and Medical Leave Act of 1993;

  * A retiree may be eligible for coverage under this Plan. Please see definition of Retired Employee or contact the Human Resources Department for additional information.

- The date beginning the period for which the Employee has failed to make any required contribution for coverage.

Retiree Coverage

If you cease Active Employment due to retirement; and you are at least age 60; and you meet the minimum service requirement of 20 years or more of employment by the Employer; and are a Retired Employee as defined by this Plan and the Employer; you and your covered spouse may continue dental coverage as noted below provided such coverage was in effect immediately prior to retirement. If you decline Retiree Coverage when initially eligible, you will not have a second chance to enroll for Retiree Coverage. Coverage for a spouse is limited to the spouse at the time the Employee retired.

Retiree coverage under this Plan shall terminate upon the earliest of any of the following events.

With respect to:

Retired Employees

- Death of the Retired Employee
- Termination of the Plan
- Termination of participation in the Plan by the Retired Employee
- Effective date of any Plan amendment that eliminates coverage for you
- The required contribution for coverage is not made

Retiree’s Spouse

- Death of Retiree’s Spouse
- Retired Employee divorce or legal separation from you
- Spouse remarriage after the death of Retired Employee
- Termination of participation in the Plan by the Retired Employee, except because of their death
- Termination of the Plan
- Effective date of any Plan amendment that eliminates coverage for you
- The required contribution for coverage is not made
Dependent Coverage Termination

A Dependent's coverage under this Plan shall terminate, upon the earlier of:

- The date the Plan is terminated or is modified to terminate Dependent coverage;
- The date the Employee's coverage terminates;
- At midnight on the last day of the month during which the Dependent ceases to be an eligible Dependent by Plan definition;
- At midnight on the last day of the month during which the Dependent ceases full-time school attendance except that:
  - If cessation is due to school vacation (either summer vacation or semester/quarter chosen by the Dependent during the school year), Dependent status shall terminate on the date the school reconvenes if attendance does not resume; or
  - If cessation is due to disability which prevents full-time school attendance, Dependent status shall terminate on the last day of the quarter/semester in which the disability occurred.
- The date beginning the period for which the Employee has failed to make any required contribution for Dependent coverage;
- The date of the Dependent's entry into the Armed Forces of any country, except for temporary active duty of 31 days or less;
- The date the Dependent becomes eligible for coverage under this Plan as an Employee.

Are Dental Benefits Paid After Coverage Ends?

Charges for root canal therapy or installation of a dental appliance, a crown, a bridge, or gold restoration furnished within 30 days after the date of termination of an individual's insurance for dental benefits under this Plan, will be Covered Expenses if:

- An impression for such appliance is taken prior to the date of termination of insurance, and
- The tooth was prepared for the crown, bridge or gold restoration, or with respect to root canal therapy when the tooth and pulp chamber is opened, prior to the date of termination of insurance, and
- The individual is not entitled to payment for such installation under other insurance of any type or source.

CONTINUATION COVERAGE RIGHTS

This Plan is not subject to Continuation Coverage Rights under COBRA.

However, if coverage ends for the Employee and/or Dependent due to ineligibility for coverage, an election to continue coverage may be made to participate in the Plan for up to three months. For policies and procedures, please direct questions to the Human Resources Department at Gustavus Adolphus College.
PROCEDURES FOR FILING OF BENEFIT CLAIMS

Post-service Claim

A Claim is any request for a Plan benefit or benefits, made by you or your authorized representative, that complies with the Plan’s reasonable procedure for filing benefit Claims.

A Post-service Claim is a Claim that is made after the dental service is provided to the Covered Person. All Claims filed under this Dental Plan are Post-service Claims.

1. A Post-service Claim is filed in accordance with the Plan’s procedures for filing of benefit Claims if all the following requirements are met:
   a. The Claim is submitted to the Plan Administrator or its agents, the Contract Administrator or Preferred Provider Network, in written or electronic form;
   b. The Claim is received within 90 days of the date of loss. If the Claim was not received within the 90 day limit, you may furnish proof as soon as reasonably possible. However, a Claim cannot be received later than one year after the date of loss, except in a case of absence of legal capacity of the Covered Person.

2. If submitted in written form, the Claim must contain the following information:
   a. Employee's name, group number and Social Security Number;
   b. Patient’s name;
   c. Provider’s name and address;
   d. Date(s) expense(s) incurred;
   e. Itemization of charges;
   f. Description of Services using codes from CDT (American Dental Association Current Dental Terminology);
   g. Diagnosis using codes from ICD-9-CM (Ninth Edition International Classification of Diseases);
   h. The provider’s TIN (Tax Identification Number);
   i. Drug Claims should include the name of the drug, the prescription number and the name of the prescribing Physician; and
   j. If payment is made directly to a provider, a signed Assignment of Benefits.

3. Written claims should be submitted as soon as possible after expenses are incurred to:

   Sheffield, Olson and McQueen, Inc.
   2145 Ford Parkway, Suite 300
   St. Paul, Minnesota 55116-1912

4. If submitted in electronic form, the Claim must be filed in accordance with transaction standards set by the federal government as part of the Health Insurance Portability and Accountability Act (HIPAA).

5. Information regarding other coverage must be provided by the Employee at intervals determined by the Plan. If the patient has other coverage, the name, address and phone number of other carriers and the effective date and termination date of other coverage must be provided. If the patient does not have other coverage, a statement that there is no other coverage must be provided.

6. If coverage under this Plan is secondary to other coverage, the other carrier’s Explanation of Benefits (EOB) must be provided.
7. The Plan must be provided with sufficient information to determine whether a Claim is correctly covered under this Plan. In the case of an accident, for example, this means making a determination as to whether the Claim is work related, or whether another form of insurance or other party is responsible for all or part of the Claim.

8. The Plan must be provided with sufficient information to determine whether a Claim is eligible for benefits under this Plan.

9. If there is a possibility of a Claim from a plan that is not a group dental plan, the Plan must be provided with a signed, dated Subrogation Statement.

10. The Plan must be provided with sufficient information to determine that the patient is a Covered Person under the terms of the Plan (for example, proof of school attendance for a covered Dependent child over age 18).

11. The Plan may request any other information which it deems necessary to process a Claim.
**BENEFIT DETERMINATION PROCEDURES**

The Plan Administrator has designated a Contract Administrator for the purposes of evaluating Claims reimbursement under the Plan.

**Required Timeframe**

The Contract Administrator will decide your Claim within a reasonable time not longer than 30 days after it is received. This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including cases where Claim information is incomplete.

If a Claim is incomplete, time is “toll" (i.e. not counted) from the date the Plan requests additional information, until such additional information is received.

**For the purposes of this Plan, a Claim is considered to be “decided” as follows:**
- A Post-service Claim is considered “decided” when the Contract Administrator generates an Explanation of Benefits (EOB).

**Notice of Extension – Post-service Claim**

If a Post-service Claim is incomplete, the Plan will notify you of the need for additional information within 30 days of the date the incomplete Claim is received.

You are allowed up to 45 days to submit additional information to complete the Claim. A second request for the missing information will be sent 21 days after the first request.

**If you do not respond within 45 days of the date the Plan requests additional information, the Claim is automatically denied.**

The Plan Administrator or Contract Administrator may secure independent dental or other advice and require such other evidence as it deems necessary to decide your Claim.

**Notice of Adverse Benefit Determination**

If your Claim is denied, in whole or in part, you will be furnished with a written notice of adverse benefit determination, which provides the following information:
1. The specific reason or reasons for the denial;
2. Reference to the specific Plan provision on which the denial is based;
3. A description of any additional material or information necessary for you to complete your Claim and an explanation of why such material or information is necessary; and
4. Appropriate information as to the steps to be taken if you wish to appeal the Claim determination, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information, with respect to any adverse determination after appeal of your Claim.

**Assignments to Providers**

All Eligible Expenses reimbursable under the Plan will be paid by the Plan to the covered Employee except that assignment of benefits to Hospitals, Physicians or other providers of service will be honored.
Reimbursements

Whenever any benefit payments which should have been made under this Plan have been made by another party, the Employer and the Contract Administrator shall be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan shall be fully discharged from liability for such payments to the full extent thereof.

Right of Recovery

Whenever any benefit payments have been made by the Plan in excess of the maximum amount required under the Plan for Covered Expenses, the Plan shall have the right to recover all such excess amounts from any persons, insurance companies or other payees, and the Employee or Dependent shall make a good faith attempt to assist the Contract Administrator in such recovery.
APPEALING A CLAIM

If your Claim is denied in whole or in part, you may appeal to the Plan Administrator or its agent, the Contract Administrator, for a review of the denied Claim. Your appeal must be made in writing within 180 days of the Plan Administrator’s initial notice of adverse benefit determination. If you do not appeal on time, you will lose your right to appeal.

Your written appeal should state the reasons that you feel your Claim should not have been denied. It should include any additional facts and/or documents that you feel support your Claim. You may also ask additional questions and make written comments, and you may review (on request and at no charge) documents and other information relevant to your appeal. The Plan Administrator or its agent, the Contract Administrator, will review all written comments you submit with your appeal.

Review of Appeal

The Plan Administrator or its agent, the Contract Administrator, will review and decide your appeal within a reasonable time, not longer than 60 days after it is submitted, and will notify you of its decision in writing. The individual who decides your appeal will not be the same individual who decided your initial Claim denial and will not be that individual’s subordinate. The Plan Administrator or its agent, the Contract Administrator, may secure independent dental or other advice and require such other evidence as it deems necessary to decide your appeal, except that any dental expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial Claim. (The identity of a dental expert consulted in connection with your appeal will be provided.) If the decision on appeal affirms the initial denial of your Claim, you will be furnished with a notice of adverse benefit determination on review setting forth:
1. The specific reason or reasons for the denial;
2. Reference to the specific Plan provision on which the denial is based;
3. A statement of your right to review (on request and at no charge) relevant documents and other information;
4. If the Plan Administrator relied on an “internal rule, guideline, protocol, or other similar criterion” in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

ERISA RIGHTS

This Plan is not subject to ERISA.