SUMMARY PLAN DESCRIPTION

Plan Number:	938919-001
Plan Effective Date:	September 1, 2020
Plan Sponsor:	Wilkes County Board of Education 613 Cherry St North Wilkesboro, NC 28659

Type of Administration: The Plan is administered by the Plan Administrator with Sun Life Assurance Company of Canada, 2323 Grand Boulevard Kansas City, Missouri 64018, acting as Dental Claims Administrator.

Employer:	Wilkes County Board of Education
Amendment Effective Date:	January 1, 2024

Plan Document

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COVERED PERSON, SPOUSE AND DEPENDENT CHILDREN DENTAL COVERAGE

Eligible Class: All Full-Time United States Employees hired on the 1st through the 15th of the month scheduled to work at least 30 hour per week

Eligibility Waiting Period: Until the first of the month following date of employment

Deductible:

Per Person Deductible: $50 per Calendar Year

Maximum Family Deductible: 3 persons individually per Calendar Year

Only one deductible applies per Calendar Year if Type II and III Dental Expenses are Incurred. The deductible is waived for Type I Dental Expenses.

Maximum Benefit:

The Per Person Maximum Benefit for Type I, II and III Dental Expenses combined is:
$1,000 per Calendar Year.

Dental Plan Benefits

Unless otherwise specified, the following benefits will be payable based on the Allowable Charge. Refer to the Covered Benefits section of this Plan Document for additional information including limitations.

Type I Covered Dental Expenses
Payable at: 100%

Oral Evaluations
Bite Wing X-Rays
Dental Prophylaxis
Genetic Test
Fluoride Treatment
Space Maintainers
Sealants
Intraoral Complete Series

Type II Covered Dental Expenses
Payable at: 80%

Extraoral X-Rays
Intraoral Occlusal X-rays
Intraoral Periapical X-rays
Palliative Treatment
Scaling and Root Planing
Periodontal Maintenance
Localized Delivery of Time Release Anti-microbial Agents into Diseased Crevicular Tissue
Root Canal Therapy
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Retrograde Filling
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1. BENEFIT HIGHLIGHTS

COVERED PERSON, SPOUSE AND DEPENDENT CHILDREN DENTAL COVERAGE

Removal of Lateral Exostosis
Frenectomy
Excision of Hyperplastic Tissue
Orantral Fistula Closure
Biopsy
Incision and Drainage
Tooth Re-implantation
General Anesthesia/IV Sedation
Amalgam Restoration
Stainless Steel Crowns
Composite Posterior Filling
Accession and examination of tissue
Pin Retention
Therapeutic Drug Injections
Consultation
Composite and Silicate Restorations

Type III Covered Dental Expenses
Payable at: 50%

Crowns
Inlays and Onlays
Fixed Bridge
Removable Full or Partial Dentures
Repair/Recement Full Dentures, Partial Dentures, Crowns, Inlays
Crown Buildup
Post and Core
Tissue Conditioning
Veneers
Clasps and Rests
Relining Dentures, Rebasing Dentures
Denture Adjustments
Implants

Contributions: The cost of your Plan contribution is shared by both you and your Employer.

2. DEFINITIONS

Actively at Work means that you perform all the regular duties of your job for a full work day at your Employer's normal place of business, a site approved by your Employer or a site where your Employer's business requires you to travel.

You are considered Actively at Work if you usually perform the regular duties of your job at your home as long as you can perform all the regular duties of your job for a full work day and could do so at your Employer's normal place of business.

You are considered Actively at Work on any day that is not your regular scheduled work day (e.g., you are on vacation or holiday) as long as you were Actively at Work on your immediately preceding scheduled work day.

Allowable Charge means:

- with respect to Covered Dental Expenses provided by a Participating Provider, the pre-determined fee:
  - made available to us under any agreement; and
  - that a Participating Provider has agreed to charge for a given service.
- with respect to Covered Dental Expenses provided by a Non-Participating Provider, a fee level that is at the 90th percentile of the amount standardly charged for like Treatment, by other providers in the Locality where the service is Incurred.
- with respect to Covered Dental Expenses provided by a Contracting Provider, the lesser of:
  - a fee level that is at the 90th percentile of the amount standardly charged for like Treatment, by other providers in the Locality where the service is Incurred; or
  - the pre-determined fee made available to us under any agreement.

Benefit Waiting Period means the period of time that a Participant must be covered under the Plan before being eligible for specific dental services.

Calendar Year means the period beginning on January 1st and ending on December 31st of the same year.

Claimant means an individual who has submitted an application for benefits under the Plan.

Contracting Provider means a Dentist who provides dental services for Non-Network Expenses at the pre-determined Allowable Charge.

Contributory means coverage for which you pay all or part of the premium.

Course of Treatment means a planned program of one or more services for the Treatment of a diagnosed dental condition.

Covered Dental Expense means the lesser of the provider's billed charge or the Allowable Charge for any dental services when that service is:

- performed by a Dentist or Denturist;
- Dentally Necessary, for the dental care of a Covered Person; and
- determined by us to have a favorable prognosis.

Covered Person means a person who is employed by the Employer within the United States, who is a U.S. citizen or a U.S. resident, scheduled to work at least the minimum hours shown in the Benefit Highlights, and paid regular earnings, and has a legitimate federal tax identification number.

If you are a Covered Person and you are working on a temporary assignment outside of the United States for 12 months or less, you will be deemed to be working within the United States. If you are a Covered Person and you are working on a temporary assignment outside of the United States for more than 12

months, you will not be considered a Covered Person under the Plan unless the Plan Sponsor agrees in Writing.

Dental Hygienist means someone who meets both of the following requirements:
- is currently licensed to practice dental hygiene by the state in which they practice; and
- is acting under the supervision of a Dentist.

Dentally Necessary means a service or Treatment that is appropriate for the diagnosis and in accordance with accepted dental standards. The service or Treatment must be essential for the care of the teeth and supporting tissues.

Dental Prophylaxis means preventive Treatment which includes scaling and polishing, the complete removal of explorer-detectable calculus, soft deposits, plaque, stains and the smoothing of tooth surfaces coronal to the gingival attachment. A multiple appointment cleaning shall be considered as a single prophylaxis.

Dentist means someone who meets both of the following requirements:
- is currently licensed to practice dentistry by the state in which they practice; and
- is acting within the scope of their license.

Denturist means someone who meets both of the following requirements:
- is currently licensed to make dentures by the state in which they practice; and
- is acting within the scope of their license.

Dependent means your Spouse and Dependent Children.

Dependent Child (Dependent Children) means your unmarried or married child under age 26.

Dependent Child includes:
- your step-child;
- a foster child placed with you by a licensed agency;
- a child for whom you have or your Spouse has legal guardianship of the child's person;
- a child for whom coverage is required pursuant to a court order;
- your adopted child, including any child placed with you for adoption.

If an unmarried child is age 26 or older and is:
- incapable of self-sustaining employment because of an intellectual disability, developmental disability, or physical handicap; and
- chiefly dependent on you for their support;

that child will continue to be considered a Dependent Child under the Plan for as long as these conditions exist.

No person may be considered to be a Dependent Child of more than one Participant.

Dependent Child does not include:
- any person who is covered as a Participant;
- your married child whose employer sponsors Dental Coverage; or
- any person residing outside the United States or Canada. This exclusion does not apply to a Dependent Child who:
  - resides with you while you are on a temporary work assignment outside the United States; or
  - is a Full-time Student attending school outside of the United States.

Eligibility Waiting Period means the length of time you must be a member in an Eligible Class before you can apply for coverage. The Eligibility Waiting Period is shown in the Benefit Highlights. Any period of

time you were Actively at Work for the Employer as a full-time Participant will count towards completion of the Eligibility Waiting Period.

Employer means the Employer named on the cover page of this Plan Document and includes any subsidiary or affiliated company named in the application.

Enrollment Period means the period of time each year not to exceed 30 days during which eligible Participants may elect, change, or cancel coverage under the Plan. The Enrollment Period cannot exceed 30 days or occur more than once in any 12-month period, unless we agree in Writing.

Family Member means: (a) your spouse or domestic partner and (b) the following relatives of you or your spouse or domestic partner: (1) parent; (2) grandparent; (3) child; (4) grandchild; (5) brother; (6) sister; (7) aunt; (8) uncle; (9) first cousin; (10) nephew or niece. This includes adopted, in-law and step-relatives.

Family Status Change means one of the following events:
- your marriage or divorce;
- the birth of your child;
- the adoption of a child by you;
- the placement of a child with you, pending adoption;
- the death of your Spouse or child;
- involuntary loss of other group dental coverage;
- loss of dental coverage under a state Medicaid plan;
- the commencement or termination of employment of your Spouse or Dependent Child;
- the change from part-time to full-time employment by you or your Spouse;
- the change from full-time to part-time employment by you or your Spouse; or
- the taking of an unpaid leave of absence by you or your Spouse.

Functioning Natural Tooth means that part of the tooth that is formed by the human body and is:
- performing its normal role in the chewing process in the upper or lower arch; and
- opposed in the other arch by another tooth or prosthetic replacement.

Fund or Trust Fund means any Fund or Trust Fund maintained in connection with the Plan.

Immediate Family includes:
- you;
- your Spouse; and
- the parents, grandparents, brothers, sisters or children of either you or your Spouse, whether related by blood or marriage.

Incur, Incurs or Incurred means the following:
- if the Plan includes coverage for any of the following services, they will be considered Incurred if started and completed while covered under the Plan:
  - full or partial dentures are considered started on the date the final impression is made and completed on the date the final completed appliance is first inserted in the mouth;
  - fixed bridges, crowns, inlays, and onlays are considered started on the date the teeth are first prepared and completed on the date an appliance is cemented in place;
  - root canal therapy is considered started on the date the pulp chamber is opened and completed on the date a canal is permanently filled;
  - implants are considered started and completed on the date the implant is inserted; or
  - if the Plan includes coverage for Type IV services, those services will be considered Incurred on the date of insertion of bands or appliance; and
- all other Covered Dental Expenses will be considered Incurred on the date the service was rendered.

Late Entrant means:

- a Covered Person who does not enroll during the times specified in the “When must you enroll for Participant Dental Coverage” section;
- a Spouse who you do not enroll during the times specified in the “When must you enroll for Spouse Dental coverage?” section;
- a Dependent Child who you do not enroll during the times specified in the “When must you enroll for Dependent Children Dental coverage?” section; or
- any Covered Person who requests reinstatement of coverage which was terminated while they remained eligible for coverage under the Plan.

Layoff means that you are temporarily not Actively at Work for a period of time your Employer agreed to in Writing. Your normal vacation time is not considered a temporary Layoff.

Leave of Absence means that you are temporarily not Actively at Work for a period of time your Employer agreed to in writing. Your normal vacation time is not considered a temporary Leave of Absence.

Locality means an area whose size is large enough, as determined by us, to give an accurate representation of standard charges for a type of dental service.

Network Expense means Covered Dental Expenses for services that are furnished by a Participating Provider.

Non-Network Expense means Covered Dental Expenses for services that are furnished by a Non-Participating Provider or Contracting Provider.

Non-Participating Provider means any Dentist who is not a Participating Provider and provides dental services for Non-Network Expenses payable based on the Allowable Charge or Contracting Provider who provides dental services for Non-Network Expenses at the pre-determined Allowable Charge.

Orthodontic Treatment means the corrective movement of teeth through bone by means of an active appliance to correct a malocclusion.

Participating Provider means any Dentist who provides dental services for Network Expenses at the pre-determined Allowable Charge.

Participation in a Riot, Rebellion or Insurrection, the words "Participation" and "Riot" in this phrase mean:
Participation includes promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but will not include actions taken in defense of public or private property, or actions taken in your own defense, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firefighters.

Riot includes all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to person or property or unlawful act or acts is the intent or the consequence of such disorder.

Periodontal Maintenance means recall procedures for patients who have had surgical or non-surgical Treatment for periodontal disease. The procedures include examination, periodontal evaluation and any further scaling and root planing that is Dentally Necessary.

Physician means a person who is operating within the scope of their license and is either:
- licensed in the United States as a medical doctor and authorized to practice medicine and prescribe and administer drugs or to perform surgery; or
- any other duly licensed medical practitioner who is deemed by applicable state law to have the same authority as a legally qualified medical doctor.

2. DEFINITIONS

The Physician cannot be you, a business associate, or any Family Member.

Plan means the group dental plan established by the Employer that describes benefits for participants and their covered dependents.

Prior Plan means the Employer's group Plan of Dental Expense Benefits that was in force on the day before the effective date of this Plan.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

Spouse means any individual who is a party to a marriage and under state, federal or provincial law is recognized as a spouse.

Spouse does not include:

- any person who is covered as a Participant; or
- any person residing outside the United States. This exclusion does not apply to your Spouse who resides with you while you are on a temporary work assignment outside the United States.

Treatment means a Dentist's consultation, care or services, or diagnostic measures.

Trust means the Trust established under the Trust Agreement.

Trust Agreement means the agreement concerning the Fund as amended from time to time.

Trustee means the entity acting as Trustee under the Trust Agreement.

We, Us, Our (we, us, our) means the Dental Claims Administrator.

Written or Writing means a record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

You, Your (you, your) means a Participant who is eligible for coverage under the Plan. Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF COVERED PERSON COVERAGE

When are you eligible for Participant Dental Coverage?
You are initially eligible for Participant Dental Coverage on the latest of:

- September 1, 2020;
- the first day of the month following your date of employment; or
- the date you first are Actively at Work in an Eligible Class.

You are also eligible for Coverage during any Enrollment Period or as a result of a Family Status Change, provided you are Actively at Work and in an Eligible Class.

When must you enroll for Participant Dental Coverage?
You must enroll within 31 days of the date you are initially eligible for Participant Dental coverage.

If you do not enroll for coverage during your initial Enrollment Period, you will not be insured for any Contributory Participant Dental Coverage.

If you do not enroll for coverage during your initial Enrollment Period, you are a Late Entrant.

If you refuse your coverage and do not enroll when you are eligible, then you will not be allowed to enroll until the next Enrollment Period and you will be a Late Entrant.

When does Participant Dental Coverage start?
Participant Dental Coverage starts on the later of the date:

- you are eligible;
- you enroll; and
- you agree to make any required contribution toward the cost of Coverage;

if you are Actively at Work on that date.

If you are not Actively at Work on that date, your Coverage will not start until you resume being Actively at Work

What are the Participant Benefit Waiting Periods?
If you are a Late Entrant you will be covered for Type I Dental Expenses on your Effective Date of Coverage. There are Benefit Waiting Periods for Type II and Type III Dental Expenses as shown below. The Benefit Waiting Periods begin on your Effective Date. The Benefit Waiting Periods for:

- Type II Dental Expenses is 12 months except Restorations – 6 months.
- Type III Dental Expenses is 24 months.

The Benefit Waiting Periods shown above will not be applied if you were enrolled in the Prior Plan.

What happens if you are rehired by your Employer?
If you are rehired by your Employer within 12 months of the date your employment ends your Coverage may be reactivated. Your reactivated Coverage will be subject to all the terms and provisions of the Plan.

If you had partially satisfied your Eligibility Waiting Period prior to your termination of employment, your previous time employed with your Employer will count towards completion of your Eligibility Waiting Period. Your Eligibility Date will be the later of the date you are rehired or the day after you complete the Eligibility Waiting Period.

If you are rehired by your Employer 12 months or later after the date your employment terminates, your coverage will not be reinstated. You will be eligible for coverage on the day after you complete a new Eligibility Waiting Period.

You must re-enroll within 31 days of your rehire date.

When does Participant Dental Coverage end?

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF COVERED PERSON COVERAGE

Your Participant Dental Coverage under the Plan will end on the earliest of the following:

- the date the Plan terminates;
- the date you are no longer in an Eligible Class;
- the date your class is no longer included for Coverage;
- the last day for which any required contribution has been paid for your Participant Dental Coverage;
- the date you notify us in Writing to cancel your Participant Dental Coverage;
- the last day of the month in which you are Actively at Work, subject to the Coverage Continuation provision;
- the date you enter active duty in any armed service during time of war, declared or undeclared;
- the last day of the month in which you retire; or
- the date you die.

If your coverage has ended, can it be reinstated?
If your coverage ends for any reason other than you have voluntarily terminated it, then you may apply to reinstate your coverage within 12 months from the date it ended. To reinstate your Coverage, you must apply within 31 days after you return to being Actively at Work in an Eligible Class. Reinstatement will be effective on the later of the date:

- you agree to make any required contribution toward the cost of your coverage; and
- you are Actively at Work.

Any Treatment occurring between your termination date and your reinstatement effective date will not be considered a Covered Expense.

A new Eligibility Waiting Period will not apply.

Your reinstated coverage will be:

- the coverage your Employer offers at the time of your reinstatement; and
- subject to all the terms and provisions of the Plan.

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE COVERAGE

When are you eligible for Spouse Dental Coverage?
If you are in an Eligible Class, you are initially eligible for Spouse Dental Coverage on the latest of:

- September 1, 2020;
- the date you are covered for Participant Dental Coverage; or
- the date you acquire a Spouse.

You are also eligible for Spouse Dental Coverage during any Enrollment Period or as a result of a Family Status Change, provided you are in an Eligible Class and have a Spouse.

What if my Spouse is not living in the United States?
If your Spouse is permanently residing outside the United States, he or she may not be covered. This exclusion does not apply to your Spouse who resides with you while you are on a temporary work assignment outside the United States.

When must you enroll for Spouse Dental Coverage?
For Contributory Spouse Dental Coverage, you must enroll within 31 days of the date you are initially eligible for Spouse Dental Coverage or within 31 days of the date of a Family Status Change or during any Enrollment Period or your Spouse will be a Late Entrant.

When does Spouse Dental Coverage start?
For Contributory Spouse Dental Coverage, Spouse Dental Coverage starts on the latest of the date:

- you are eligible for Spouse Dental Coverage;
- you are covered under the Plan for Participant Dental Coverage;
- you enroll for Spouse Dental Coverage; and
- you agree to make any required contribution toward the cost of Coverage;

if you are Actively at Work on that date.

If you are not Actively at Work on that date, your Spouse Dental Coverage will not start until you resume being Actively at Work.

What are the Spouse Benefit Waiting Periods?
If you are a Late Entrant or your Spouse is a Late Entrant your Spouse will be covered for Type I Dental Expenses on your Spouse's Effective Date of Coverage. There are Benefit Waiting Periods for Type II and Type III Dental Expenses as shown below. The Benefit Waiting Periods for Late Entrants begin on your Spouse's Effective Date. The Benefit Waiting Periods for:

- Type II Dental Expenses is 12 months except Restorations – 6 months.
- Type III Dental Expenses is 24 months.

The Benefit Waiting Periods shown above will not be applied if your Spouse was enrolled in the Prior Plan.

When does Spouse Dental Coverage end?
Spouse Dental Coverage will end on the earliest of the following to occur:

- the date the Plan terminates;
- the date you are no longer in an Eligible Class;
- the date your class is no longer included for Coverage;
- the last day for which any required contribution has been paid for your Coverage or your Spouse Coverage;
- the date you are no longer covered under the Plan;
- the date you notify us in Writing to cancel your Spouse Dental Coverage;
- the last day of the month in which you are Actively at Work, subject to any Coverage Continuation provisions provided;
- the date your Spouse enters active duty in any armed service during time of war, declared or undeclared;

- the date your Spouse no longer meets the definition of Spouse as described in this Plan Document;
- the last day of the month in which you retire;
- the date you die; or
- the date your Spouse dies.

5. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN COVERAGE

When are you eligible for Dependent Children Dental Coverage?
If you are in an Eligible Class, then you are initially eligible for Dependent Children Dental Coverage on the latest of:

- September 1, 2020;
- the date you are covered for Participant Dental Coverage; or
- the date you acquire your Dependent Children.

You are also eligible for Dependent Children Dental Coverage during any Enrollment Period or as a result of a Family Status Change, provided you are in an Eligible Class and have one or more Dependent Children.

When must you enroll for Dependent Children Dental Coverage?
For Contributory Dependent Children Dental Coverage, you must enroll within 31 days of the later of the date:

- you are initially eligible for Dependent Children Dental Coverage; or
- your Dependent Child reaches age 3;

or your Dependent Child will be a Late Entrant.

When does Dependent Children Dental Coverage start?
For Contributory Dependent Children Dental Coverage, Dependent Children Dental Coverage starts on the latest of the date:

- you are eligible for Dependent Children Dental Coverage;
- you are first covered under the Plan, for Participant Dental Coverage;
- you enroll for Dependent Children Dental Coverage; and
- you agree to make any required contribution toward the cost of Coverage;

if you are Actively at Work on that date.

If you are not Actively at Work, your Dependent Children Dental Coverage will not start until you resume being Actively at Work.

What are the Dependent Children Benefit Waiting Periods?
If you are a Late Entrant or your Dependent Child is a Late Entrant your Dependent Child will be covered for Type I Dental Expenses on your Dependent Child's Effective Date of Coverage. There are Benefit Waiting Periods for Type II and Type III Dental Expenses as shown below. The Benefit Waiting Periods for Late Entrants begin on your Dependent Child's Effective Date. The Benefit Waiting Periods for:

- Type II Dental Expenses is 12 months except Restorations – 6 months.
- Type III Dental Expenses is 24 months.

The Benefit Waiting Periods shown above will not be applied if your Dependent Child was enrolled in the Prior Plan.

How does Dependent Children Dental Coverage apply to newborn children, newly placed foster children or newly adopted children?
If you are covered under the Plan but do not have Dependent Children Dental Coverage when a newborn child, newly placed foster child or newly adopted child becomes one of your Dependent Children, then such child will automatically be covered for 31 days from the date they become your Dependent Child. To continue coverage beyond 31 days, you must:

- enroll for Dependent Children Dental Coverage within 31 days from the date the newborn child, newly placed foster child or newly adopted child becomes your Dependent Child; and
- pay the required contribution to continue your Dependent Children Dental Coverage.

If you are covered under the Plan and have Dependent Children Dental Coverage when a newborn, newly placed foster child or newly adopted child becomes one of your Dependent Children, then such child will automatically be covered.

5. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN COVERAGE

When does Dependent Children Dental Coverage end?

Dependent Children Dental Coverage will end on the earliest of the following to occur:

- the date the Plan terminates;
- the date you are no longer in an Eligible Class;
- the date your class is no longer included for Coverage;
- the last day for which any required contribution has been paid for your Coverage or your Dependent Children Dental Coverage;
- the date you are no longer covered under the Plan;
- the date you notify us in Writing to cancel your Dependent Children Dental Coverage;
- the last day of the month in which you are Actively at Work, subject to any Coverage Continuation provisions provided;
- the date your Dependent Child enters active duty in any armed service during time of war, declared or undeclared;
- the last day of the month in which your Dependent Child no longer meets the definition of Dependent Child as described in this Plan Document, but only with respect to that person; or
- the last day of the month in which you retire; or
- the date you die; or
- the date your Dependent Child dies.

6. COVERED DENTAL BENEFITS

What is the Dental Benefit?
We will pay a Dental Benefit if a Covered Person Incurs Covered Dental Expenses for any of the services shown below. Payments for Covered Dental Expenses are based on the Allowable Charge and type of service – Type I, Type II or Type III. The percentage payable for each type of service is shown in the Benefit Highlights. Dental Benefits are only available for Covered Dental Expenses that are Incurred while a Covered Person is covered under the Plan.

Are you required to get a Pre-Determination of Benefits?
We recommend a Pre-Determination of Benefits for:

- extensive Treatment such as root canal therapy, crowns, bridges and periodontal Treatment, if those services are included under this Plan; or
- any Treatment for which charges will exceed $300.

We recommend that the Course of Treatment be submitted to us for review before Treatment begins. We will notify you and the Dentist of the benefits payable based upon the Course of Treatment. In determining the amount of benefits payable, we will consider alternate dental Treatment that will, as determined by us, accomplish a professionally satisfactory result. If you and the Dentist agree to a more costly method of Treatment, than that determined by us, the excess amount will not be paid by us.

Pre-Determination of Benefits is not required. If you do not submit a Pre-Determination of Benefits the amount of benefits payable by us is not affected.

Pre-Determination of Benefits is not an agreement for payment of the dental expenses. The pre-determination process lets the Participant or a covered dependent know in advance approximately what portion of the expenses will be considered covered dental expenses under the Plan.

What is the alternate dental Treatment benefit?
If we determine that alternate procedures, services or Courses of Treatment can be performed to correct a dental condition, payment will be considered for the least costly procedure which we determine will produce a professionally satisfactory result. No alternate dental Treatment benefit is payable for any service that is not a Covered Dental Expense.

Under what conditions are benefits payable?
Our payment of benefits is subject to all the terms and conditions of the Plan. We will not pay benefits for any one item of expense under more than one provision of the Plan. All related dental expenses will be considered as part of the most comprehensive procedure and only the benefit for that procedure will be payable.

What are providers entitled to collect from you?
If a Covered Person uses the services of a Participating Provider or a Contracting Provider for Covered Dental Expenses, those providers are entitled to collect from you the difference between the amount of benefits payable by us and the lesser of the provider’s billed charge or the Allowable Charge. If we pay a benefit for an alternate dental Treatment, a Participating Provider or a Contracting Provider is entitled to collect from you the difference between the amount of benefits payable by us and the lesser of the provider’s billed charge or the Allowable Charge for the service provided.

If a Covered Person uses the services of a Non-Participating Provider, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the provider's billed charge.

What benefits are payable for Type I, Type II and Type III Covered Dental Expenses?
If during a Calendar Year a Covered Person Incurs Covered Dental Expenses in excess of the Deductible, the benefit payable will be:

- equal to the applicable percentage shown in the Benefit Highlights;
- subject to any Benefit Waiting Periods; and
- limited to the Calendar Year Maximum Benefit.

6. COVERED DENTAL BENEFITS

What is the Deductible?
The Per Person Deductible is the amount of Covered Dental Expenses that a Covered Person must Incur in a Calendar Year before any benefits are payable. The Per Person Deductible per Calendar Year for each type of Covered Dental Expense is shown in the Benefit Highlights. The amounts to be applied to meet the Deductible must be charges for Covered Dental Expenses.

Amounts applied for your family will not exceed the Maximum Family Deductible shown in the Benefit Highlights in any Calendar Year, even if the Per Person Deductible has not been met.

The Maximum Family Deductible shown in the Benefit Highlights is the number of Covered Persons in your family who must each Incur Covered Dental Expenses in excess of the Per Person Deductible. Once the Maximum Family Deductible is met, Covered Dental Expenses are payable even if the Per Person Deductible has not been met.

If a Covered Person Incurs Covered Dental Expenses for Type I Services, those expenses are not subject to the Per Person Deductible.

What is the Calendar Year Maximum Benefit?
The Per Person Maximum Benefit in each Calendar Year for Type I, II and III Dental Expenses combined is shown in the Benefit Highlights. The Calendar Year Maximum Benefit applies to all periods of time the Participant is covered during a Calendar Year regardless of any interruption in coverage for this Coverage. This Maximum Benefit applies to all Covered Dental Expenses.

Does your Treatment have to have a favorable prognosis?
Benefits will be considered only for Treatment that we determine has a reasonably favorable prognosis of correcting the Covered Person's dental condition for a period of at least 3 years.

Are benefits payable for temporary work?
Benefits for temporary dental service including temporary prosthetics will be considered a part of the final dental service. By temporary prosthetics we mean any prosthetic inserted and used by a Participant for fewer than 12 months. Any prosthetic inserted and used by a Participant for at least 12 months will be considered permanent in nature.

Are any benefits payable after your Coverage terminates?
No benefits are available after a Participant's Coverage ends except that benefits are available:

- for procedures requiring multiple visits if the Treatment is started while a Participant is covered under the Plan and completed within 30 days after the Participant's Coverage ends. Treatment is considered started when the tooth is irrevocably altered. This extension is limited to crowns, fixed bridges, inlays, onlays, full dentures, partial dentures and root canal therapy if such services are included under this Plan; and
- until the end of the calendar year quarter in which Coverage ends, for Orthodontic Treatment Incurred while covered under the Plan if such services are included under the Plan.

A pre-determination for any Course of Treatment is not Treatment started.

What are Covered Dental Expenses?
The following is a list of those dental services which will be considered as Covered Dental Expenses. Covered Dental Expenses are based on current dental terminology which is updated from time to time. The most current terms may not be shown but benefits will be based on the most current dental terminology. Covered Dental Expenses must be Incurred while a Participant is covered under the Plan.

TYPE I DENTAL SERVICES
Oral Evaluations

Oral Evaluations are limited to 1 of these services in any 6 consecutive month period.

Bitewing X-rays
Bitewing X-rays are limited to 1 set (2 or 4 films) in any 12 consecutive month period.

Intraoral Complete Series
These x-rays are limited to 1 panorex or complete series in any 60 consecutive month period. Ten or more individual periapical x-rays and/or bitewing films or a panoramic film will be considered a complete series for benefit purposes.

Dental Prophylaxis
Dental Prophylaxis is limited to 1 time in any 6 consecutive month period. The number of Dental Prophylaxis and Periodontal Maintenance is combined and is limited to 4 in any 12 consecutive month period.

Genetic Test
A Genetic Test for susceptibility to oral diseases is limited to once per lifetime and to persons over age 18.

Fluoride Treatments
Fluoride Treatments are limited to 1 time in any 6 consecutive month period for Dependent Children under age 14.

Space Maintainers
Space Maintainers are limited to 1 per tooth in any 3 year period for Dependent Children under age 19 when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not develop. Benefits include all adjustments within 6 consecutive months of installation.

Sealants
Sealants are limited to 1 time per tooth in any 36 consecutive month period, to the occlusal surface of unrestored permanent first and second molars, and to Dependent Children under age 14.

TYPE II DENTAL SERVICES
There is a Benefit Waiting Period for Type II Covered Dental Expenses. The Benefit Waiting Period will not be applied if the Covered Person was enrolled in the Prior Plan.

Diagnostic Services
Accession and Examination of Tissue

Extraoral X-rays
Extraoral X-rays are limited to 1 film in any 6 consecutive month period.

Intraoral Periapical X-rays
Intraoral Periapical X-rays are limited to 4 films in any 12 consecutive month period.

Intraoral Occlusal X-rays
Intraoral Occlusal X-rays are limited to 2 films in any 12 consecutive month period.

Endodontic Services
Root Canal Therapy
Root Canal Therapy (including teeth treated prior to the Plan Effective Date) includes all pre-operative, operative, and post-operative x-rays; canal preparation and fitting of preformed dowel or post; bacteriologic cultures, diagnostic tests, local anesthesia, and routine follow-up care. Root Canal Therapy is limited to 1 time per tooth in any 24 consecutive month period.

Apicoectomy/Periradicular Surgery
Benefits for Apicoectomy/Periradicular Surgery include all pre-operative, operative, and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.

Retrograde Filling
Retrograde Fillings are limited to 1 per root.

Hemisection
Benefits for Hemisection include any root removal, local anesthesia, and routine post-operative care. Benefits for root canal therapy are not included.

Pulpotomy
Pulpotomy is limited to Dependent Children under age 19.

Root Amputation

Non-surgical Periodontal Services

Scaling and Root Planing
Scaling and Root Planing is limited to 1 time per quadrant of the mouth in any 24 consecutive month period. It is not payable in addition to Dental Prophylaxis or Periodontal Maintenance performed on the same day.

Periodontal Maintenance following Active Periodontal Therapy
Periodontal Maintenance following active Periodontal Therapy is limited to 1 time in any 3 consecutive month period. The number of Periodontal Maintenance and Dental Prophylaxis is combined and is limited to 4 in any 12 consecutive month period.

Localized Delivery of Time Release Anti-microbial Agents into Diseased Crevicular Tissue
Localized delivery of time release anti-microbial agents into diseased crevicular tissue is limited to 1 time per tooth in any 12 consecutive month period.

Surgical Periodontal Services
Benefits for the following services are limited to only one of these procedures per quadrant, in any 36 consecutive month period.

Gingivectomy

Gingivoplasty

Osseous Surgery

Guided Tissue Regeneration

Osseous Graft
Osseous Graft is further limited to Treatment for periodontal disease. It is not covered when performed following an extraction at the same site.

Pedicle Graft

Tissue Grafts

Crown Lengthening

Distal or Proximal Wedge Procedure

Oral Surgery Services

Simple Extraction

Surgical Extraction of Erupted Teeth, Impacted Teeth, or Exposed Root
Multiple surgical services on one area of the mouth will be based on the most inclusive procedure and includes local anesthesia and routine post-operative care.

Alveoplasty
Multiple surgical services on one area of the mouth will be based on the most inclusive procedure and includes local anesthesia and routine post-operative care.

Vestibuloplasty
Multiple surgical services on one area of the mouth will be based on the most inclusive procedure and includes local anesthesia and routine post-operative care.

Removal of Lateral Exostosis
Multiple surgical services on one area of the mouth will be based on the most inclusive procedure and includes local anesthesia and routine post-operative care.

Frenectomy
Multiple surgical services on one area of the mouth will be based on the most inclusive procedure and includes local anesthesia and routine post-operative care.

Excision of Hyperplastic Tissue
Excision of Hyperplastic Tissue is limited to 1 time per arch. Multiple surgical services on one area of the mouth will be based on the most inclusive procedure and includes local anesthesia and routine post-operative care.

Orantral Fistula Closure
Multiple surgical services on one area of the mouth will be based on the most inclusive procedure and includes local anesthesia and routine post-operative care.

Biopsy

Incision and Drainage
Incision and Drainage is not covered as a separate expense when performed with a single extraction.

Tooth Re-implantation or Stabilization

General Anesthesia and IV Sedation
General Anesthesia and IV Sedation are limited to three 15 minute units. Benefits for General Anesthesia are limited to the benefit for IV sedation. Benefits for General Anesthesia and IV Sedation are payable as a separate expense only when required for the surgical extraction of an impacted tooth.

Restorations

Amalgam Restorations
Amalgam Restorations are limited to one restoration per tooth in any 24 consecutive month period. Multiple restorations on one surface will be considered one restoration for benefit purposes. Restorations on 2 non-occlusal adjacent tooth surfaces will be considered 1 surface for benefit purposes.

Composite and Silicate Restorations
Composite and Silicate Restorations are limited to one restoration per tooth in any 24 consecutive month period. Restorations on 2 non-occlusal adjacent tooth surfaces will be considered 1 surface for benefit purposes.

Pin Retention
Pin Retention is limited to 1 time per restoration and is not covered in addition to cast restorations.

Other Type II Services
Consultation
These services are paid as a separate benefit only if performed by a Dentist who is not providing operative Treatment.

Therapeutic Drug Injections

Palliative Treatment
Palliative Treatment, including sedative fillings, are paid as a separate benefit only if no Treatment, except x-rays, was rendered during the visit.

Stainless Steel Crowns
Stainless Steel Crowns are covered only if the tooth cannot be restored by an amalgam or composite filling and are limited to 1 time in any 36 consecutive month period and to Dependent Children under age 19.

TYPE III DENTAL SERVICES
There is a Benefit Waiting Period for Type III Covered Dental Expenses. The Benefit Waiting Period will not be applied if the Covered Person was enrolled in the Prior Plan.

Restorations

Inlays and Onlays
Inlays and Onlays are covered only if the tooth has extensive decay or fracture and cannot be restored by an amalgam or composite filling. Inlays and Onlays are limited to 1 per tooth in any 10 year period and to persons over age 16.

Crown Buildup
A Crown Buildup, including pins and pre-fabricated posts will be paid as a separate procedure only when required for placement of a crown if that crown is a Covered Expense and is limited to 1 per tooth in any 10 year period.

Crowns
Crowns, including Porcelain Crowns on anterior teeth, are covered only if the tooth has extensive decay or fracture and cannot be restored by an amalgam or composite filling. Benefits include temporary restorations and follow-up care within 12 months of insertion. Crowns are limited to 1 per tooth in any 10 year period and to persons over age 16.

Veneers
Veneers are limited to anterior teeth and covered only if the tooth cannot be restored by a filling or by other means. Veneers are limited to 1 per tooth in any 10 year period and to persons over age 16.

Post and Core
Post and Core is covered only for a tooth treated by a root canal that requires a crown. Post and Core is limited to 1 per tooth in any 10 year period.

Prosthodontics
Removable Full Dentures
Benefits for Removable Full Dentures include temporary restorations, appliances, and follow-up care within 12 months of insertion. Benefits for personalized dentures, overdentures or associated Treatment will be considered a part of the final dental service. Replacement of Removable Full Dentures is limited to 1 per arch in any 10 year period and only if the Denture cannot be made serviceable.

Removable Partial Dentures
Benefits for Removable Partial Dentures include all temporary restorations, clasps, rests, teeth, and follow-up care within 12 months of insertion. Replacement of Removable Partial Dentures is limited to 1 per arch in any 10 year period and only if the Denture cannot be made serviceable.

Clasps and Rests
Benefits for additional Clasps and Rests are provided after 12 months of insertion.

Relining Dentures, Rebasing Dentures
Relining or Rebasing Dentures are considered part of the denture charges if services are provided by the same Dentist and are within 12 months of insertion. Subsequent relining or rebasing is limited to 1 time in any 36 consecutive month period.

Denture Adjustments
Denture Adjustments are considered part of the denture charges if services are provided by the same Dentist and are within 12 months of insertion. Subsequent adjustments are limited to 1 time in any 12 consecutive month period.

Tissue Conditioning
Tissue Conditioning is limited to services performed after 12 months of the insertion of the Denture.

Fixed Bridges
Benefits for Fixed Bridges are limited to persons over age 16 and include temporary restorations, appliances, and follow-up care within 12 months of insertion. Unless there was a Dentally Necessary extraction of an additional Functioning Natural Tooth and that tooth was not an abutment to an existing bridge, replacement of Fixed Bridges is limited to 1 per arch in any 10 year period and only if the Bridge cannot be made serviceable.

Implant Services
Implants
Implants are limited to 1 in any 10 year period and only if the Implant cannot be made serviceable. Implant abutments are limited to 1 per Implant.

Other Type III Services

Repair/Recement Full Dentures, Partial Dentures, Crowns, Inlays
Repairs to, or recementing of, Full Dentures, Partial Dentures, Crowns, or Inlays are covered 12 months after insertion.

7. EXCLUSIONS

What exclusions apply to the benefits payable?
Covered Dental Expenses do not include and no benefits are provided for:

- procedures which are not included in the list shown in the “Covered Dental Benefits: What are Covered Dental Expenses?” section.
- dental care which is not customarily performed or which is experimental in nature. By experimental, we mean: the use of any Treatment, procedure, facility, equipment, drug, or drug usage device or supply which we determine is not acceptable standard dental Treatment of the condition being treated. Any such items requiring federal or other governmental agency approval which was not granted at the time the services were rendered will also be considered experimental. In making the determination as to whether dental care is experimental, we will rely on the advice of the general dental community including, but not limited to dental consultants and dental journals and/or regulations.
- charges for oral hygiene instruction, a plaque control program, tobacco counseling, dietary instruction or other educational services.
- charges for house or hospital calls for dental services and for hospitalization costs (e.g. facility-use fees).
- charges for prescription and non-prescription drugs, vitamins or dietary supplements.
- charges for medical exams prior to oral surgery.
- charges for procedures that are:
  - part of a service but are reported as separate services;
  - reported in a Treatment sequence that is not appropriate; or
  - misreported or that represent a procedure other than the one reported.
- charges made by a Dentist, Dental Hygienist, or Denturist who:
  - normally lives in the Participant's home;
  - is a member of your Immediate Family;
  - is a Participant of the Plan Sponsor; or
  - is a Plan Sponsor.
- charges for Treatment that is not Dentally Necessary or not deemed to be within generally accepted standards of dental Treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the determination will be made by us.
- charges for completion of claim forms or failure to keep appointments.
- charges for any of the following:
  - dental care resulting from war or an act of war, or any involvement in any period of any type of armed conflict (this does not include acts of terrorism);
  - active participation in a war (declared or undeclared);
  - active military duty;
  - dental care resulting from any injury which is self-inflicted or not caused by an accident;
  - dental care resulting from active Participation in a Riot; Rebellion, or Insurrection;
  - dental care resulting from the commission or attempted commission of an assault, felony or other criminal act.
- dental care arising out of or in the course of employment for pay or profit or which is covered by Workers' Compensation or a similar law, or for which the Participant is entitled to payment under an automobile Coverage Plan. Benefits paid by us would be in excess to the third-party benefits and therefore, we would have the right of recovery for any benefits paid in excess.
- Covered Dental Expenses Incurred while Coverage is not in force under the Plan.
- charges for incomplete Treatment (e.g. patient does not return to complete Treatment) and charges for temporary services (e.g. temporary restorations).
- charges for care, Treatment, services, or supplies to the extent that any benefit is provided by Medicare.
- charges which are not customarily made when there is no Coverage, or charges for which there is no legal obligation to pay.
- charges for Treatment performed outside the United States except for a Maximum Benefit of $100 for emergency dental Treatment performed outside the United States.

7. EXCLUSIONS

- procedures which are elective.
- procedures that we determine are cosmetic in nature.
- replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
- specialized procedures and techniques (e.g. precision or semi-precision attachments, copings, over dentures or customized prostheses or attachments).
- a fixed bridge that replaces the extracted portion of a hemisected tooth.
- duplicate dentures, prosthetic devices or any other duplicative device.
- charges for bridges, partial or full dentures, inlays, onlays, crowns, implant crowns and other laboratory prepared restorations if they can, as determined by us, be satisfactorily restored with an amalgam or composite filling.
- the initial placement of implants, implant crowns, bridges, or partial or full dentures to replace teeth missing on the effective date of the Participant's coverage under the Plan, including congenitally missing teeth. Benefits will be payable for Covered Dental Expenses for bridges, or dentures if the prosthesis includes the initial replacement of a Functioning Natural Tooth that is extracted by a Dentist while the Covered Person is covered under the Plan except that the replacement of:
  - an extracted tooth will not be considered a Covered Dental Expense if it was an abutment to an existing prosthesis;
  - those teeth extracted while a Participant is covered under the Plan will be considered a Covered Dental Expense; and
  - teeth missing on a Participant's effective date will not be considered a Covered Dental Expense.

  Benefits will be payable for Covered Dental Expenses for implants, implant crowns, bridges, or partial or full dentures, to replace a tooth that was extracted while the Participant was covered under the Prior Plan. Such extraction must have occurred within the preceding 12 months and have been a covered expense under the Prior Plan. No benefits will be payable for any expenses that are payable under the Prior Plan's extension of benefits provision.
- charges for replacement of bridges, partial or full dentures, inlays, onlays, crowns, implant crowns and other laboratory prepared restorations if they can, as determined by us, be satisfactorily repaired and restored to function.
- charges for pulp caps.
- charges for diagnostic casts.
- charges for Treatment of fractures and dislocations of the jaw.
- charges for Treatment of malignancies or neoplasms.
- charges for desensitizing medications.
- administration of nitrous oxide or other agent to control anxiety.
- charges for occlusal adjustments.
- charges for periodontal splinting of teeth by any method.
- charges for orthodontic Treatment.
- charges for retention of orthodontic relationships.
- charges for Treatment whose primary purpose is to:
  - change or maintain vertical dimension;
  - alteration or restoration of occlusion, except for occlusal adjustment in conjunction with periodontal surgery;
  - bite registration, or bite analysis;
  - treat attrition or abrasion.
- charges for diagnostic services and Treatment of jaw joint problems by any method. Examples of these jaw joint problems are temporomandibular joint disorders or other conditions of the joint linking the jaw bone and the complex muscles, nerves and other tissues related to the joint.
- charges for any Treatment of congenital mouth malformations or skeletal imbalances (e.g. Treatment related to cleft lip or cleft palate, disharmony of facial bone or required as the result of orthognathic surgery including Orthodontic Treatment).

8. CLAIM PROVISIONS

How is a claim submitted?
To submit a claim, you or someone on your behalf must send us Written notice and proof of claim within the time limits specified.

NOTICE OF CLAIM

When does Written notice of claim have to be submitted?
Written notice of claim must be given to us no later than 90 days after the date the expense is Incurred. If notice cannot be given within the applicable time period, we must be notified as soon as it is reasonably possible.

When we receive Written notice of claim, we will send the forms for proof of claim. If the forms are not received within 15 days after Written notice of claim is sent, proof of claim may be sent to us without waiting to receive the proof of claim forms.

PROOF OF CLAIM

When does Written proof of claim have to be submitted?
Written proof of claim must be given to us no later than 90 days after the date the expense is Incurred.

If proof cannot be given within the time limit, proof must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time proof is otherwise required unless you are legally incompetent.

What is considered proof of claim?
Proof of claim is any information that we may reasonably require to verify the eligibility or coverage of any Participant. We may require any of the following:

- a complete dental chart showing:
  - extractions;
  - missing teeth;
  - fillings;
  - prostheses;
  - periodontal pocket depths; and
  - the date of any work previously performed.
- an itemized bill for all dental care.
- the following exhibits:
  - x-rays;
  - study models;
  - laboratory and/or hospital records.
- a dental examination at our expense by a Dentist whom we choose.
- any other information we may require to make a claim determination.

We may require as part of the proof, authorizations to obtain dental and non-dental information. Proof must be satisfactory to us.

PAYMENT OF BENEFITS

When will a decision on your claim be made?
We will send you a Written notice of our decision on your claim within a reasonable time after we receive the claim but not later than 30 days after receipt of your proof of claim. If we cannot make a decision within 30 days after receiving your claim, we will request a 15 day extension as permitted by U.S. Department of Labor regulations. Any request for extension will specifically explain:

- the standards on which entitlement to benefits is based;
- the unresolved issues that prevent a decision on the claim; and
- the additional information needed to resolve those issues.

If a period of time is extended because you failed to provide necessary information, the period for making the benefit determination is tolled from the date we send notice of the extension to you until the date on which you respond to the request for additional information. You will have 45 days to provide the specified information.

When are benefits payable?
Benefits are payable upon our receipt of satisfactory proof of claim that establishes benefit eligibility according to the provisions of the Plan.

What if your claim is denied?
If we deny all or any part of your claim, you will receive a Written notice of denial setting forth:

- the specific reasons for the denial;
- the specific Plan provisions on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary;
- a description of the appeal procedures and time limits;
- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request.

What is the appeal procedure?
If a claim is denied in whole or in part as recommended by the Dental Claims Administrator the following claims appeal procedure shall be observed:

- The claimant, or the claimant's duly authorized representative, may appeal the denial by submitting to the Plan Administrator or the Dental Claims Administrator a written request for review of the claim within 180 days after receiving written notice of such denial from the Dental Claims Administrator. Failure by the claimant to submit a request for review within 180 days after receiving the denial of benefits shall constitute a waiver by the claimant of the right to appeal the decision. The Plan Administrator or the Dental Claims Administrator shall, upon the claimant's request, give the claimant an opportunity to review relevant documents, other than legally privileged documents, in preparing such request for review.
- The request for review must be in writing and shall be addressed as follows:
  Sun Life
  P.O. Box 2940
  Clinton, IA 52733-2940

- The request for review shall set forth all of the grounds upon which it is based, all facts in support thereof and any other matters which the claimant deems pertinent. The Plan Administrator or the Dental Claims Administrator may require the claimant to submit, at the expense of the claimant, such additional facts, documents or other material as are necessary or advisable in conducting the review.
- The Dental Claims Administrator shall act upon each request for review within 60 days after the Dental Claim Administrator receives the request for review.
- In the event the Plan Administrator confirms the denial of the claim for benefits in whole or in part, written notice of the Plan Administrator's decision shall be given to the claimant. Such notice shall be written in a manner calculated to be understood by the claimant and shall contain the specific reasons for the denial.

Is an appeal necessary before filing a lawsuit?
No legal action for benefits under the Plan shall be brought unless and until the following has occurred:

- The claimant has submitted a proper written claim for benefits;
- The claimant has been notified by the Dental Claims Administrator that the claim is denied.
- The claimant has filed a written appeal with the Plan Administrator or the Dental Claims Administrator for review of the denied claim as recommended by the Dental Claims Administrator.

- The claimant has been notified in writing of the Plan Administrator's decision to uphold the denial or the Plan Administrator has failed to take any action on the request for review within the time prescribed by the terms of the Plan.

To whom are benefits payable?
We will pay you if your proof of claim is satisfactory except in the following situations:
- a Covered Person assigns benefits to a provider. In such case, we may pay the benefits directly to the provider.
- you are a minor. In such case, claim may be made by your duly appointed guardian, conservator or committee and we will pay to such person or persons.
- due to physical or mental incapacity, you cannot, in our judgment, give us a valid receipt for payments. In such case, claim may be made as described above.
- you die before we pay you. In such case, claim may be made by your executor or the administrator of your estate and we will pay to such person or persons.

COORDINATION OF BENEFITS

What is Coordination of Benefits?
If a Covered Person is covered under more than one dental plan, the benefits from other Plans will be taken into account. This may require a reduction in benefits under this Plan, so that the combined benefits will not be more than the Allowable Expenses of this Plan and any other Plan.

What is a Plan?
For purpose of Coordination of Benefits (COB), a Plan is any plan that provides dental expense benefits or services under:
- group Coverage, individual Coverage or any other insured or uninsured arrangement of coverage; or
- basic automobile reparations (no-fault) Coverage, but only:
  - to the extent of the benefits required by or available under the applicable no-fault law; and
  - if such no-fault Coverage does not, under its rules, determine its benefits after the benefits of any group health Coverage.

The term "Plan" will be construed as follows:
- separately with respect to each Plan, contract, or other arrangement for benefits or services; and
- separately with respect to each of the following:
  - that part of any such Plan, contract, or other arrangement which reserves the right to take into account the benefits or services of other Plans in determining benefits; and
  - that part which does not reserve such right.

Benefits payable under another Plan include the benefits that would have been payable if claim had been made for them.

What is an Allowable Expense?
For purpose of COB, an Allowable Expense is any necessary, reasonable, and customary item of Covered Dental Expense (as shown in the “What are Covered Dental Expenses?” section) that is at least partly covered under at least one of the Plans covering the Participant for whom claim is made. When a Plan provides benefits in the form of services rather than cash, the value of each service will be considered to be both an Allowable Expense and a benefit paid.

How are benefits computed under COB?
In a Calendar Year, this Plan will always either pay its regular benefits in full, or it will pay a reduced amount which, when added to the benefits payable and the cash value of any services provided by the other Plans, will equal 100% of the Allowable Expenses Incurred by the Participant for whom claim is being made.

Are there any limits on the use of COB?
In computing the benefits under this Plan, the benefits under any other Plan will not be included if:
- the other Plan contains a COB provision that:
  - provides for coordinating its benefits with those of this Plan; and

    - under its terms, would compute its benefits after we compute the benefits under this Plan; and
- the rules shown in the "How are plans' benefits determined" section require that this Plan's benefits are computed before the other Plan computes its benefits.

How are plans' benefits determined?
To determine whether we will reduce the benefit we would have paid if COB had not been included, it is necessary to determine the order in which the various Plans will pay benefits.
This will be determined as follows:

- a Plan with no COB provision will be considered to pay its benefits before a Plan that contains such a provision.
- a Plan that covers a person other than as a dependent will be considered to pay its benefits before a Plan that covers that person as a dependent.
- a Plan that covers a person as a dependent of a Participant whose month and day of birth occur earlier in the calendar year will be considered to pay its benefits before a Plan that covers that person as a dependent of a Participant whose month and day of birth occur later in the calendar year. If, however, the COB provisions of any other Plan do not contain a rule like the one described in the preceding sentence, then such rule will not apply and the applicable rule set forth in such other Plan shall determine the order of benefit payment. However, if the parents of a dependent child are separated, divorced, or not living together, whether or not they have ever been married, the following rules apply:
    - if there is a court decree that sets responsibility for the child's health care, a Plan that covers the child as a dependent of the parent with such responsibility will be considered to pay its benefits before any other Plan that covers the child as a dependent child; otherwise
    - if the parent with custody of the child has not remarried, a Plan that covers the child as a dependent of that parent will be considered to pay its benefits before a Plan that covers the child as a dependent of the parent without custody.
    - if the parent with custody of the child has remarried:
        - a Plan that covers the child as a dependent of that parent will be considered to pay its benefits before a Plan that covers that child as a dependent of the step-parent; and
        - a Plan that covers such child as a dependent of the step-parent will be considered to pay its benefits before a Plan that covers the child as a dependent of the parent without custody.
- Where the rules above do not establish the order of payment, the Plan under which the person has been covered for the longer period of time will be considered to pay its benefits before the other. However:
    - a Plan that covers a person as a laid-off or retired Participant, or as a dependent of such a person, will be considered to pay its benefits after a Plan that covers such person as other than a laid-off or retired Participant, or as a dependent of such a person. If the other Plan does not contain this rule, then this rule shall not apply.

What are our rights under COB?
We have the right to release or obtain any information and make or recover any payments we consider necessary in order to administer this provision.

We may, without the consent of or notice to any person, release to or obtain from any other Coverage company, organization or person, any information, with respect to any person, that may be needed to apply the terms of the COB provision or any similar provision of any other Plan.

Any person who claims benefits under this Plan must furnish to us any information that we may need to apply the COB provision. For the purposes of this section only, any person who is covered under this Plan will be deemed to have authorized us to secure the information necessary to apply the terms of this provision.

8. CLAIM PROVISIONS

What if a Plan makes a payment that should have been made by us?
If any payment that should have been made under this Plan according to the COB provision is made under any other Plan, we have the right to pay to the organization that made such payment any amount that, in our judgement, will satisfy the intent of the COB provision. Any amount so paid will:

- be deemed a benefit paid under this Plan; and
- fully discharge us from our liability under this Plan

What if we overpay a claim?
If a payment made under this Plan is in excess of the total amount required to satisfy the intent of the COB provision, we have the right to recover any excess amount from any person to whom, for whom, or with respect to whom such payment is made.

9. COVERAGE CONTINUATION

Are there any conditions under which your Employer can continue your Coverage?
While the Plan is in force and subject to the conditions stated in the Plan, your Employer may continue your Coverage that was in force on the date immediately before the date you ceased to be Actively at Work by paying the required contributions to us for any of the following reasons and durations:

- Absence due to injury, sickness or pregnancy – up to 12 months
- Layoff – up to 3 months
- Leave of Absence (including Family and Medical Leave of Absences) – up to 3 months
- School Recess – up to 3 months
- Vacation – based on your Employer's Plan, not to exceed 3 months

While the Plan is in force, you may be eligible to continue your Coverage as long as your Employer keeps paying contributions on your behalf. You should contact your Employer for more details.

While the Plan is in force, you may be eligible to continue your Coverage pursuant to the Family and Medical Leave Act of 1993, as amended or continue coverage pursuant to a state required continuation period (if any). You should contact your Employer for more details.

While the Plan is in force, you may be eligible to continue your Coverage pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA). You should contact your Employer for more details.

Are there any conditions under which you can continue your Coverage?
Federal law requires certain employers to offer continuation coverage to Participants for a specified period of time upon termination of employment or reduction of work hours for any reason other than gross misconduct. You should contact your Employer to find out whether or not this requirement applies. Your Employer will advise you of your rights to continuation coverage, if any, and the cost.

If this requirement does apply, you must elect to continue coverage within 60 days from your Family Status Change or notification of rights by your Employer, whichever is later.

You may elect to extend coverage for your eligible Dependents, or your eligible Dependents may elect to continue coverage under certain circumstances or due to a Family Status Change or a child stops being eligible for coverage under the Plan as a "Dependent Child". Dependents must elect to continue coverage within 60 days from the event or notification of rights by your Employer, whichever is later.

You must pay for COBRA continuation coverage directly to the Plan Administrator. The Plan Administrator is responsible for administering COBRA continuation coverage.

10. CONTINUITY OF COVERAGE

What happens if your Employer replaces other dental coverage with this Plan?
If a Participant was covered under the Prior Plan, the Continuity of Coverage benefits set forth in this Section may be available.

What if you are not Actively at Work when your Employer replaces the Prior Plan with this Plan?
You and your Dependents will be covered under this Plan if you are not Actively at Work on September 1, 2020 if:

- you were covered under the Prior Plan on the day before the Plan Effective Date; and
- you are a member of an Eligible Class.

Do any waiting periods apply when your Employer's Prior Plan is replaced with this Plan?
We will apply any period of time satisfied under the Prior Plan to meet the requirements of the Eligibility Waiting Period toward the satisfaction of the period of time required by this Plan's Eligibility Waiting Period.

Do any benefit waiting periods apply when your Employer's Prior Plan is replaced with this Plan?
We will waive the Benefit Waiting Period for any Participant who was covered under the Prior Plan on the day before the Effective Date of this Plan.

If a Participant was eligible for coverage but not covered under the Prior Plan on the day before the Effective Date of this Plan, the Late Entrant Benefit Waiting Period will apply.

Are benefits payable for Treatment you started before the effective date of this Plan?
If a Covered Person Incurs Covered Dental Expenses for a Course of Treatment that is started while covered under the Prior Plan and is completed while covered under this Plan, benefits for that Participant may be payable under the terms of this Plan except that:

- no benefits will be payable for any expenses that are payable under the Prior Plan's extension of benefits provision;
- benefits will be payable for only those Covered Dental Expenses Incurred during that portion of the Course of Treatment that the Participant received while they were covered under this Plan; and
- if the Prior Plan had no extension of benefits provision, benefits under this Plan will be based on the percentage of Treatment performed while covered under the Prior Plan.

The Maximum Benefit and any other limits on amounts or time limitations on benefits payable under this Plan shall be reduced by any corresponding amounts or limitations previously paid or satisfied, whether in whole or in part, under the terms of the Prior Plan.

What happens to your Deductible and Maximum Benefit if you were covered under the Prior Plan?
For the Calendar Year in which this Plan becomes effective, we will reduce a Participant's Deductible and Maximum Benefit under this Plan by any amount of Covered Dental Expenses that are Incurred in the Calendar Year in which this Plan becomes effective and applied toward the Prior Plan's deductible and maximum benefit for such year.

A Participant's Deductible under this Plan cannot be reduced unless we receive the deductible and maximum benefit information of the Prior Plan and subtract any reductions made to the Prior Plan's maximum benefit from the Maximum Benefit of the Plan.

11. GENERAL PROVISIONS

ALTERATION

Who can alter this Plan Document?
The only party with the authority to alter or modify this Plan Document or to waive any of its provisions is the Employer.

APPLICABLE LAW

Are there any laws this Plan adheres to?
The validity and effect of the Plan and the rights and obligations of all persons affected thereby, are to be construed and determined in accordance with applicable federal law, and to the extent that federal law is inapplicable, under the laws of the State of North Carolina.

ASSIGNMENT

Can benefits be assigned (to whom payable)?
If the Participant or covered dependent assigns dental benefits to the provider of the dental treatment, any benefits payable under the Plan will be paid directly to the provider. Otherwise, any benefits payable under the Plan will be paid to the Participant. After the Participant's death, the Dental Claims Administrator has the option to pay any benefits payable under the Plan to the Participant's spouse; to the providers of the treatment; or to the Participant's estate.

CLERICAL ERROR

What happens when there is a clerical error in the administration of the Plan?
Clerical errors in connection with the Plan or delays in keeping records for the Plan by the Employer or third party administrator:

- will not terminate Coverage that would otherwise have been effective; and
- will not continue Coverage that would otherwise have ceased or should not have been in effect.

DISCRETION OF PLAN ADMINISTRATOR

Who has discretion to interpret plan provisions?
The discretionary responsibility and authority to determine eligibility for participation in the Plan and to interpret Plan provisions and to determine whether a claim will be paid or denied rests solely with the Plan Administrator.

ENTIRE PLAN

Is this document the only thing I need to understand my coverage?
This document is a complete statement of the Plan and as of the effective date listed on the Execution Page supersedes all prior plans, proposals, representations, promises and inducements, written or oral, relating to its subject matter. The Employers shall not be bound by or liable to any person for any representation, promise or inducement made by any person which is not embodied in this document or in any authorized written amendment to the Plan.

HEADINGS NOT TO CONTROL

Do the headings in this Plan document also apply to my coverage?
Headings and titles within the Plan are for convenience only and are not to be read as part of the text of the Plan.

11. GENERAL PROVISIONS

NO GUARANTY OF EMPLOYMENT

If I have a copy of this Plan Document, does that mean I'm included as an Employee?
The Plan does not constitute a contract between an Employer and any employee and is not a consideration for, or an inducement for, the employment of any employee by an Employer. Nothing contained in the Plan shall be deemed to give any employee the right to be retained in the services of an Employer or to interfere with the Employer's right to terminate the employment of an employee at any time without regard to the effect the termination may have on such employee's participation in the Plan.

REIMBURSEMENT

What if a benefit is overpaid?
If a benefit is paid under the Plan and it is later shown that a lesser amount should have been paid, the Plan will be entitled to a refund of the excess amount from the provider or the Participant.

SEPARABILITY OF PLAN PROVISIONS

What if a provision changes after I receive my Plan Document?
If any provisions of the Plan are declared invalid or not enforceable for any reason, such provisions will not affect the remaining terms and conditions which shall be construed and enforced thereafter as if such invalid or unenforceable provisions had not been inserted.

UNIFORMITY

How are the plan provisions interpreted and applied?
All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner.

12. CONTRIBUTIONS TO THE FUND

Actuarial Determinations and Methods

From time to time the Plan Administrator shall determine the amount of total contributions necessary to fund the liabilities and expenses of the Plan for the relevant time period. In establishing the liabilities and the contributions under the Plan, such methods and assumptions as will reasonably reflect the cost of the benefits will be utilized.

Participating Employer Contributions

From time to time, the Adopting Employer and certain Participating Employers, as determined by the Plan Administrator, may contribute to the Plan Administrator, Dental Claims Administrator or any Trust Fund an amount determined by the Plan Administrator to be necessary to provide the benefits under the Plan determined by the application of accepted actuarial methods and assumptions. The method of funding shall be consistent with the Plan objectives. From time to time, the Adopting Employer and certain Participating Employers, as determined by the Plan Administrator, shall contribute to the Plan Administrator, Dental Claims Administrator or any Trust Fund an amount determined by the Plan Administrator to be necessary to provide for the expenses necessarily incurred to establish and maintain the Plan.

Employee Contributions

From time to time, each Participant of certain Employers shall contribute to any Trust Fund such amounts as may be required under the Plan in accordance with a uniform, nondiscriminatory procedure established by the Plan Administrator.

Trust Fund

As part of the Plan, a Trust Fund may be created by the Adopting Employer under which the Trustee or Trustees receives any designated contributions of Participants and Employers and holds, invests and distributes the Fund in accordance with the terms and provisions thereof. All expenses incident to administering the Trust shall be paid out of the Fund.

Source of Benefits

If a Trust Fund is created under the above section, all benefits under the Plan shall be provided solely from the Fund, and neither the Plan Administrator, Plan Sponsor, Adopting Employer, or the Participating Employers or either their officers, directors or stockholders shall have any liability or responsibility therefor. Neither the Plan Administrator, Plan Sponsor, Adopting Employer, nor the Participating Employers, shall be liable in any manner should the Fund be insufficient to provide for the payment of any benefit under the Plan.

13. ADMINISTRATION

Powers, Duties and Responsibilities of Plan Administrator

The primary responsibility of the Plan Administrator is to administer the Plan for the exclusive benefit of the Participants and their covered Dependents, subject to the specific terms of the Plan. The Plan Administrator shall administer the Plan in accordance with its terms and shall have the power to determine all questions arising in connection with the administration, interpretation, and application of the Plan. Any such determination by the Plan Administrator may correct any defect, supply any information, or reconcile any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of this Plan; provided, however, that any interpretation or construction shall be done in a nondiscriminatory manner and shall be consistent with the intent that the Plan shall comply with the terms of ERISA and all regulations issued pursuant thereto. The Plan Administrator shall have all discretionary authority to accomplish his duties under this Plan.

The Plan Administrator shall be charged with the duties of the general administration of the Plan, including, but not limited to, the following:

(1) to determine all questions relating to the eligibility of employees to participate or continue participation hereunder;

(2) to maintain all necessary records for the administration of the Plan;

(3) to interpret the provisions of the Plan and to make such rules for regulation of the Plan as are consistent with hereof;

(4) to determine the size and type of any contract to be purchased from any insurer, and to designate the insurer from which such contract shall be purchased;

(5) to direct the computation and certification from time to time of the sums of money necessary or desirable to be contributed to any Trust Fund;

(6) to assist any Participant regarding his rights, benefits or elections available under the Plan;

(7) to communicate to employees, Participants and their covered dependents a summary plan description outlining the provisions of the Plan as required under Title I of ERISA;

(8) to review and decide appeals by claimants from the denial of benefits as recommended by the Dental Claims Administrator;

(9) to appoint or employ one or more persons to assist in the administration of the Plan or to render advice with regard to any of its responsibilities under the Plan;

(10) to proscribe procedures to be followed by employees making claims for benefits; and

(11) to request from Employers, Participants and employees such information as shall be necessary for proper administration of the Plan.

Reliance Upon Information

In making decisions under the Plan, the Plan Administrator shall be entitled to rely upon information furnished by an employee, Employers, Participants, Dental Claims Administrator, counsel, doctor or Dentist.

13. ADMINISTRATION

Records and Reports

The Plan Administrator shall keep a record of all actions taken and shall keep all other books of account, record, and other data that may be necessary for proper administration of the Plan and shall be responsible for supplying all information and reports to the Internal Revenue Service, Department of Labor, Participant, and others as required by law.

Information from Participating Employers

To enable the Plan Administrator to perform its functions, Employers shall supply full and timely information to the Plan Administrator on all matters as the Plan Administrator may require. The Plan Administrator may rely upon such information as is supplied by Employers and shall have no duty or responsibility to verify such information.

14. AMENDMENT AND TERMINATION OF THE PLAN

Amendment and Termination of the Plan

The Adopting Employer intends for the Plan to continue indefinitely; however, the Adopting Employer reserves the right to alter, amend or terminate this Plan at any time, for any reason, in whole or in part, provided that no amendment shall authorize or permit any part of any Trust Fund to be used or diverted to any purpose other than to the exclusive benefit of the Participants. Notwithstanding the foregoing, this Plan may be amended at any time to conform its provisions to the requirements of ERISA, the Internal Revenue Code, Treasury Regulations or rulings thereunder.

Final Distribution Upon Plan Termination

As provided in the section above, the Adopting Employer shall have the right to terminate this Plan at any time for any reason. Upon a complete termination, no part of any Trust Fund shall be used or diverted to any purpose other than to the exclusive benefit of the Participants, unless otherwise permitted by law.

15. NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

INTRODUCTION

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group dental coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights.

The Plan Administrator is:

Wilkes County Board of Education
613 Cherry St
North Wilkesboro, NC 28659
(336) 667-1121

The Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of the Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and Dependent Children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or

(2) Your employment ends for any reason other than your gross misconduct.

Your Dependent Spouse will become a qualified beneficiary if your dependent spouse loses coverage under the Plan because any of the following qualifying events happens:

(1) You die;

(2) Your hours of employment are reduced;

(3) Your employment ends for any reason other than gross misconduct; or

(4) You become divorced or legally separated from your spouse.

Your Dependent Children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

(1) You die;

(2) Your hours of employment are reduced;

(3) Your employment ends for any reason other than gross misconduct;

(4) You become divorced or legally separated; or

(5) The child stops being eligible for coverage under the Plan as a “Dependent Child.”

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator 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 employee, the Employer must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

For the other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent Child’s losing eligibility for coverage as a Dependent Child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to:

Wilkes County Board of Education
613 Cherry St
North Wilkesboro, NC 28659
(336) 667-1121

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a Dependent Child losing eligibility as a Dependent Child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage lasts for up to 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 you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. This notice should be sent to:

Wilkes County Board of Education
613 Cherry St
North Wilkesboro, NC 28659
(336) 667-1121

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, your Spouse and Dependent Children can receive additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to your Spouse and Dependent Children if you die or you get divorced or legally separated. The extension is also available to a Dependent Child when that child stops being eligible under the Plan as a Dependent Child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to:

15. NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Wilkes County Board of Education
613 Cherry St
North Wilkesboro, NC 28659
(336) 667-1121

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact:

Wilkes County Board of Education
613 Cherry St
North Wilkesboro, NC 28659
(336) 667-1121

or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

16. QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is an order from a court or administrative agency that enforces the medical child support obligations of a non-custodial parent. A National Medical Support Notice (NMSN) issued by a state agency if properly completed is accepted as a QMCSO.

To qualify as a QMCSO the order must clearly specify certain information as follows:

(a) The name and address of the Participant (the employee) and the name and address of the alternate recipient (any child of the Participant who is recognized under the Order as having a right to enrollment) or the alternate recipient's designee.
(b) Type of coverage to be provided.
(c) Period to which the Order applies.

If the Order requires any type or form of benefit or any option not otherwise provided under the Plan, then such Order shall not qualify as a QMCSO. If the Order is deemed to meet the requirements to qualify as a QMCSO and the Participant has waived coverage or is enrolled in a different level of coverage (for example single coverage) the Plan Administrator is required to enroll the Participant and qualified alternate recipient in the appropriate Plan; applicable premiums associated with the level of coverage will be withheld from the Participant's paycheck.

A complete description of what qualifies as a QMSCO along with the procedures that must be followed by the Plan Administrator and the submitting entity is available from your Plan Administrator. Orders being submitted for consideration should be directed to the Plan Administrator.

17. COMPLIANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

Use and Disclosure of Protected Health Information

Notwithstanding any provision in this Plan to the contrary, the Plan will use and disclose Protected Health Information (PHI) only to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the applicable provisions of the American Recovery and Reinvestment Act of 2009 Title XIII, Subtitle D (Pub. L. No 111-5 (2009)) (HITECH) and all implementing regulations (45 C.F.R. Part 160-164). Specifically, the Plan will use and disclose PHI for purposes related to dental care treatment, payment for dental care, and/or dental care operations.

Special Definitions

Individually Identifiable Health Information: health information that is created or received by the Plan or the Employer which relates to the past, present or future physical or mental health or condition of an individual or the past, present or future provision of health/dental care to an individual, and which identifies (or provides a reasonable basis for identifying) such individual.

Plan Administration Functions: administration of functions performed by the Employer on behalf of the Plan and excludes functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.

Protected Health Information: Individually Identifiable Health Information except as specifically excluded from this definition, that is (i) transmitted by electronic media; (ii) maintained in any medium described in the definition of electronic media at 45 C.F.R. 162.103; or (iii) transmitted or maintained in any other form or medium. Protected Health Information excludes Individually Identifiable Health Information in (i) education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) employment records held by a covered entity in its role as Employer.

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

Certification by the Employer

Neither the Plan, nor any business associate servicing the Plan shall disclose a Participant's PHI to the Employer unless the Employer certifies that the Plan has been amended to incorporate HIPAA's privacy provisions and agrees to abide by such privacy provisions.
Pursuant to the certification

The Employer must agree to the following:

(a) not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
(b) ensure that any agents, including subcontractors, 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;
(c) not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
(d) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by the individual with respect to whom the PHI relates;
(e) report to the Plan any use or disclosure of PHI of which it becomes aware that is not permitted under the Plan's privacy policies and procedures or the HIPAA privacy regulations;
(f) make PHI available to an individual in accordance with HIPAA's access requirements;

(g) make PHI available for amendment by an individual and incorporate any amendments to PHI in accordance with HIPAA;
(h) make available the information required to provide an accounting of disclosures;
(i) 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
(j) 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 disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

Adequate Separation Between the Plan and the Employer Must Be Maintained

In accordance with HIPAA, the Plan must provide for adequate separation between those employees who will have access to PHI in order to perform Plan Administration Functions and all other employees. For purposes of this Plan only the following employees and classes of employees of the Employer may be given access to PHI:

(a) Those employees performing Plan Administration Functions on behalf of the Employer
(b) Other employees designated by the Employer.

Limitations of Protected Health Information Access and Disclosure

The employees and class of employees identified in the above paragraph may only have access to and use and disclose PHI for Plan Administration Functions that the Employer performs for the Plan.

Noncompliance Mechanism

The employees or class of employees identified above will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer, for any use or disclosure of PHI and breach or violation of or noncompliance with the provisions of this section. The Employer will promptly report such breach, violation or noncompliance to the Plan as required above and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance on any person, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.