

FORMULA DENTAL SUMMARY PLAN DESCRIPTION



For all the smiles...

...and all the smiles to come sm

**NORTHWESTERN HEALTH SCIENCES
UNIVERSITY**

Effective Date: January 1, 2005

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GENERAL INFORMATION

Name of Plan: Northwestern Health Sciences University
Employee Dental Benefit Plan

Type of Plan: Self-funded Welfare Plan

Plan Administrator: Northwestern Health Sciences University
2501 West 84th Street
Bloomington MN 55431

Group Number: 900093

Employer Tax ID Number: 41-0684657

Plan Effective Date: January 1, 2005

Plan Renewal Date: January 1

Plan Year Ends: December 31

Agent for Legal Service: Northwestern Health Sciences University

Contract Administrator: Formula Dental
3265 Northwood Circle, Suite 170
Eagan, MN 55121

Effective Date of Coverage: First of the month following enrollment.

Termination Date of Coverage: The last day of the month in which the employee terminated.

SCHEDULE OF DENTAL BENEFITS

Deductible Amount: (waived for Preventive: TYPE I Services)

- **Single**.....\$50.00
- **Family**\$100.00

Calendar Year Maximum Amount \$1,000.00 per Person per Calendar Year

Orthodontic Lifetime Maximum Amount\$1,500.00 per Person per Lifetime

Preventive Services: TYPE I **100%**

Includes:

- Fluoride Treatment (Children Only)
- Oral Examinations (2 per year limit)
- Prophylaxis
- Space Maintainers
- X-rays

Basic Services: TYPE II..... **80%**

Includes:

- Periodontic Treatment
- Scaling & Root Planing
- Fillings
- Root Canal Therapy
- Extractions

Major Services: TYPE III **50%**

Includes:

- Crowns
- Dentures
- Bridgework
- Repairs to Crowns, Dentures & Bridgework
- TMJ (Excludes appliances for tooth movement or guidance, electronic diagnostic modalities, occlusal analysis, or muscle testing. \$1000 lifetime maximum; does not go toward calendar year maximum.)

Orthodontics: TYPE IV **50%**

- For dependents under age 19

ELIGIBILITY & ENROLLMENT EMPLOYEES

A-ELIGIBLE EMPLOYEES

All full-time or part-time employees of the Employer who regularly works **twenty (20)** or more hours per week will be eligible to enroll for coverage under this Plan. Other employees such as part-time, temporary or seasonal will not be eligible to enroll for coverage under this Plan

B-PLAN ENROLLMENT

An Eligible Employee who elects to participate in the Plan, must complete, sign and return the provided "enrollment form" to the Employer within thirty-one (31) days of the Eligibility Date. Failure to enroll within this time limit will be deemed waiver of participation and the employee will be considered a Late Enrollee or Special Enrollee.

Special Enrollee: If the employee waives participation because of coverage through the employee's spouse's employer-sponsored plan, and that coverage terminates due to loss of eligibility, coverage will be guaranteed under this Plan provided enrollment is made within thirty-one (31) days following that termination date.

Late Enrollee: A Late Enrollee will be eligible to enroll for coverage subject to the Late Enrollment Restriction.

C-RETURN TO WORK – USERRA

Employees who are covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA) will be eligible for coverage on the date they return to work, provided the employee returns to work with the Employer within the specified time period in the Uniformed Services Employment and Reemployment Rights Act (USERRA). Coverage for a reservist will be on the same basis it is for active employees and dependents. The Late Enrollment Restriction will be imposed only to the extent they were applicable prior to the period of uniformed services.

ELIGIBILITY & ENROLLMENT DEPENDENTS

A-ELIGIBLE DEPENDENTS

Eligible Dependents will be a Covered Employee's legally married spouse or authorized domestic partner and each unmarried child who is not yet age nineteen (19), provided such dependent is dependent on the employee for support and maintenance. (Under certain circumstances the employee may be required to provide the Plan with proof of dependency).

The term "child", as used herein, shall be defined as: (a) a natural born child; (b) a stepchild; (c) and adopted child (from the date of placement with the employee for the purpose of legal adoption); (d) a child for whom the employee is the legal guardian, until the date the child no longer qualifies as an Eligible Dependent as defined under this Plan; or (e) a child for whom the employee is required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Contract Administrator at no cost.

No individual may be covered under this Plan as both an employee and a dependent. Also, no individual will be considered an Eligible Dependent of more than one employee.

B-ELIGIBILITY EXTENSION FOR DEPENDENT CHILDREN

Full-Time Student: If an unmarried dependent child is a Full-Time Student and is principally dependent upon the employee for support and maintenance, then such child will continue to be an Eligible Dependent until the date they attain age twenty-five (25).

Mentally or Physically Handicapped Child: If an unmarried dependent child upon reaching age nineteen (19), is incapacitated, unable to be self-supporting, and resides with the employee, then such child will continue to be an Eligible Dependent.

The employee may be required to provide the Plan with written evidence of a child's Full-Time Student or handicapped status.

C-PLAN ENROLLMENT

An Eligible Dependent is able to participate in the Plan when the Covered Employee completes, signs, and returns an enrollment form indicating dependent coverage to the Employer. The employee must enroll the dependent(s) within thirty-one (31) days of whichever of the following occurs first:

1. The employee's Eligibility Date if the employee has any Eligible Dependents at that time; or
2. The date that employee acquires an Eligible Dependent.

Children covered by Qualified Medical Child Support Orders (QMCSO) may be enrolled in this Plan if the employee would otherwise be eligible for coverage regardless of whether the employee is currently enrolled. The Plan must enroll the child (ren) and the employee covered by the notice without any enrollment restrictions (i.e. they will not be considered Late Enrollees).

If dependent coverage is already in force, the employee does not have to enroll additional dependent children acquired after dependent coverage is in force.

Newborn children and adopted children will be covered on the date of birth or adoption (or placement for adoption) if enrolled within thirty-one (31) days of the birth, adoption or placement of adoption.

Failure to enroll for dependent coverage within this time limit will be deemed waiver of participation and future coverage for dependents under the Plan will be subject to the Late Enrollee or Special Enrollee provisions.

Exception: If the coverage was waived for the spouse, the employee will be guaranteed coverage for the first dependent child, and any other dependents child acquired thereafter, provided the employee enrolls the first child within thirty-one (31) days from the date of acquisition.

Special Enrollee: If the employee waived dependent coverage because of coverage through the spouse's employer-sponsored plan, and that coverage terminates due to loss of eligibility, the dependents will be guaranteed coverage under this Plan, provided application for dependent coverage is made within thirty-one (31) days following that termination date.

Late Enrollee: A Late Enrollee will be eligible to enroll for coverage subject to the Late Enrollment Restriction.

LATE ENROLLMENT RESTRICTION

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

EFFECTIVE DATE OF COVERAGE

A-EMPLOYEES

Coverage for an Eligible Employee who enrolls in the Plan will be effective on whichever of the following occurs first:

1. The employee's eligibility date if the employee enrolls within thirty-one (31) days thereafter;
2. The day following the date the employee satisfies the Late Enrollment Restriction; or
3. The day following the date the employee's group coverage terminated through the spouse's employer, provided enrollment is made within thirty-one (31) days.

However, coverage will not become effective if the employee is not Actively-At-Work on that date, but will be delayed until the date the employee returns to active full-time work. This provision does not apply to an employee covered under the Employer's previous plan on the day immediately preceding the effective date of the Plan.

B-DEPENDENTS

When a Covered Employee enrolls any Eligible Dependents in the Plan as previously indicated, a dependent's coverage will be effective on whichever of the following occurs later:

1. The employee's effective date;
2. The date the dependent was acquired;
3. The day following the date the dependent satisfies the Late Enrollment Restriction; or
4. The day following the date the dependent's group coverage through the spouse's employer is terminated provided enrollment is made within thirty-one (31) days.

However, a dependent's coverage will not become effective if on the day coverage would normally start, the dependent is Totally Disabled and/or confined for medical care or treatment (in a Hospital, at home or elsewhere), but will be delayed until the date the dependent is no longer disabled or confined. This provision does not apply to a dependent who was covered under the Employer's previous plan on the day immediately preceding the effective date of this Plan or to a newborn dependent child.

ELIGIBLE DENTAL EXPENSES

If a Covered Person incurs expenses for a service on the list of "Eligible Dental Expenses," such charges are covered to the extent that they;

1. Are Usual and Customary;
2. Constitute necessary treatment; and
3. Are incurred while covered under this Plan.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted.

DATE EXPENSES ARE INCURRED

An expense is incurred when the service is performed, except that it is deemed to be incurred:

1. When the impression is taken in the case of dentures, or fixed bridgework;
2. When preparation of the tooth is begun in the case of crown work;
3. When the pulp chamber is opened in the case of root canal therapy.

PRE-DETERMINATION OF BENEFITS

When the total cost of eligible dental expenses is expected to exceed the Pre-Determination Limit as shown in the **Schedule of Benefits**, the Dentist's treatment plan should be sent to the Contract Administrator before the first date of treatment. Based on the treatment plan, the Contract Administrator will estimate the amount of the benefit available if treatment is performed and inform the Dentist of the determination.

The treatment plan should:

1. Show the Dentist's proposed course of treatment;

2. Show the total charge for the treatment;
3. Include x-rays, study models and any other data requested by the Contract Administrator; and
4. Show how long the treatment will take.

Pre-determination is not necessary when eligible dental expenses are incurred for emergency dental care of accidental dental care or accidental dental injuries.

Pre-treatment review is not a guarantee of the benefits that will be payable. It tells the Covered Person and the Dentist, in advance, what is payable for the eligible dental services named in the treatment plan. But payment is conditioned on:

1. The work being done as proposed and while the Covered Person is covered under this Plan; and
2. The deductible and payment limit provisions and all of the other terms of this Plan.

ALTERNATIVE TREATMENT

In all cases in which there are optional treatments available which produce a professionally satisfactory result, only the least costly alternative will be considered eligible under this Plan.

ELIGIBLE DENTAL EXPENSES

The following is a complete list of dental procedures covered under this Dental Expense Benefit, any procedure not listed is excluded.

TYPE I - PREVENTIVE EXPENSES:

1. Routine oral examinations, limited to twice per calendar year.
2. X-rays as follows:
 - a. Full mouth x-rays once in any five (5) year period, unless special need is shown;
 - b. Bitewing x-rays, limited to once per twelve (12) month period
 - c. Periapical x-rays.
3. Prophylaxis (cleaning, scaling, and polishing), but not more often than once per six (6) month period.
4. Topical application of fluoride for dependent children under age nineteen (19), limited to one treatment in any twelve (12) month period.
5. Space maintainers for missing posterior teeth.

TYPE II – BASIC RESTORATIVE EXPENSES:

1. General anesthesia in connection with covered oral surgery only.
2. Emergency palliative treatment.

3. Scaling and Root Planing.
4. Root canal therapy on permanent teeth.
5. Non-surgical periodontics at three (3) year intervals.
6. Surgical periodontics at three (3) year intervals.
7. Fillings: amalgam, acrylic and synthetic.
8. Surgical and non-surgical extractions.
9. Oral surgery.

TYPE III – MAJOR RESTORATIVE EXPENSES:

1. Crowns at five (5) year intervals.
2. Gold fillings, inlays and onlays.
3. Initial installation of, or addition to, full or partial dentures or fixed bridgework. (Dentures and bridgework will be considered to be initially installed only if the dentures or bridgework do not replace existing dentures or bridgework.) Such denture or bridgework includes the replacement of any extracted teeth and must be completed within twelve (12) months of when work is started.
4. Replacement or alteration of full or partial denture or fixed bridgework, if more than five (5) years after the last installation. Such expenses must have occurred on or after the effective date of coverage under the Plan, and must be completed within (12) months.
5. Denture adjustments and repairs.
6. Recement bridge.
7. Bridge repair.
8. TMJ (Excludes appliances for tooth movement or guidance, electronic diagnostic modalities, occlusal analysis, or muscle testing. \$1000 lifetime maximum; does not go toward calendar year maximum.)

TYPE IV – ORTHODONTIC EXPENSES:

Charges of a dentist for treatment, material and supplies furnished to a participant in connection with orthodontic treatment. There is a maximum lifetime benefit of \$1,500 for orthodontics.

Benefits paid for orthodontic treatment will not reduce the Maximum Benefit per Calendar Year for other dental charges.

DENTAL EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Plan for expenses incurred by a Covered Person for the expenses of circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered

person, or from future benefits, and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

1. Expenses incurred **prior to the effective date** of coverage, or **after the termination date** of coverage will not be considered eligible.
2. Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for wage or profit (self-employment) or for which the Covered person would be entitled to compensation under any **Worker's Compensation Law** or occupational disease law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Worker's Compensation or similar law and have reached the maximum reimbursement paid under Worker's Compensation or similar law will not be eligible for payment under this Plan.

3. Expenses for the treatment of illness or Injury **resulting from war** of any act of war, whether declared or undeclared, or while in the armed forces of any country or international organization will not be considered eligible.
4. Expenses which do not **meet the standards** of dental practices accepted by the American Dental Association, or for services **not prescribed as necessary** by a physician or Dentist will not be considered eligible.
5. Expenses for services received from a Dentist or dental department maintained by an employer, labor union, etc., where the individual is **eligible under any group insurance plan** will not be considered eligible.
6. Expenses for services and supplies, which are provided by any governmental agency, for which the Covered Person is not liable for payment, will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered person eligible under TRICARE (the government sponsored program for military dependents).
7. Expenses for treatment at a facility owned or **operated by the government** will not be considered eligible, unless the Covered Person is legally obligated to pay. This does not apply to covered expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.
8. Expenses for **hospital expenses** will not be considered eligible.
9. Expenses for **installation, replacement** or alteration of, or addition to, dentures or fixed bridgework will not be considered eligible, except as shown in **Eligible Dental Expenses**.
10. Expenses for services or supplies partially or wholly **cosmetic in nature** will not be considered eligible.
11. Expenses for **tooth implants and related services** will not be considered eligible.
12. Expenses for **mouth guards** or **take home items** will not be considered eligible.
13. Expenses for **oral hygiene**, dietary or plaque control programs, or other educational programs will not be considered eligible.

14. Expenses for **duplicate prosthetic devices** or appliances; expenses for a lost or stolen dental appliance will not be considered eligible.
15. Expenses for a **temporary full prosthesis** or for adjustment or relining of a prosthesis within six (6) months after the prosthesis is initially furnished will not be considered eligible.
16. Expenses for treatment **by other than a Dentist** or physician, except charges for treatment performed under the supervision and direction of a Dentist or physician, by any person duly licensed or certified to perform such treatment under applicable professional statutes and regulations will not be considered eligible.
17. Expenses for procedures or restorations **other than those listed** in the **Eligible Dental Expenses** section will not be considered eligible.
18. Expenses where there are **alternate courses** of treatment available carrying different fees, the Plan will provide benefits only for the treatment carrying the lesser fee.
19. Expenses in excess of the **Usual and Customary Charge** will not be considered eligible.
20. Expenses for completion of claim forms, **missed appointments** or telephone consultations will not be considered eligible.

DEFINITIONS

ACTIVELY-AT-WORK/ACTIVE WORK: An employee will be considered Actively-at-Work or in Active Work on a day which is a scheduled work day if the employee is: (1) performing in the customary manner all of the regular duties of the occupation on a full-time basis either at the customary place of employment or at some location to which travel is required; (2) absent solely by reason of vacation; (3) on a day which is not a scheduled work day only if the employee was performing in the customary manner all of the regular duties of the occupation on the last preceding scheduled work day.

ADVERSE BENEFIT DETERMINATION: Means any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A termination of benefits; or
4. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on determination or a Claimant's eligibility to participate in the Plan.

AUTHORIZED REPRESENTATIVE: A Claimant may authorize a representative to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Claimant must authorize the representative in writing, and this written authorization must be provided to the Plan. The Plan will recognize this Authorized Representative when the Plan receives the written authorization. In the case of a claim involving urgent care, a Health Care Professional with knowledge of the Claimant's dental condition is also permitted to act as the Claimant's Authorized Representative.

CALENDER YEAR: January 1 through December 31 each year.

CLAIM FOR BENEFITS: A request for a plan benefit or benefits made by a claimant in accordance with a Plan's reasonable procedure for filing benefit claims. A claim for benefits includes any Pre-Service and Post-Service Claims. A request for benefits includes a request for coverage determination, for pre-authorization or approval of a plan benefit, or for a utilization review determination in accordance with the terms of the Plan.

CLAIMANT: A person requesting benefits under the Plan. A Claimant may or may not be a Covered Person under the Plan.

CO-INSURANCE: The percentage of eligible expenses a Covered Person is required to pay as shown in the **Schedule of Benefits**.

CONCURRENT CARE: Ongoing care or course of treatment.

CONTRACT ADMINISTRATOR: The organization providing services to the Employer in connection with the operation of this Plan and performing such other functions, including processing of claims, as may be delegated to it.

COVERED EMPLOYEE: An Eligible Employee whose coverage has become effective and has not terminated.

COVERED PERSON: An Eligible Employee or Eligible Dependent whose coverage has become effective and has not terminated.

DEDUCTIBLE: The total amount of eligible expenses, as indicated in the **Schedule of Benefits**, which must be incurred by a Covered Person during any Calendar Year before covered expenses are payable under the Plan. The family Deductible maximum, as shown in the **Schedule of Benefits**, is the maximum amount, which must be uncured by the covered family members during a Calendar Year. However, each individual in a family is not required to contribute more than one individual Deductible amount to the family Deductible.

Deductible amounts satisfied with the Employer-sponsored plan immediately replaced by this Plan will be credited toward satisfaction of this Plan's Deductible requirements.

DENTIST: An individual who is duly licensed to practice dentistry or to perform oral surgery in the state where the service is performed and operating within the scope of such license. A physician will be considered a Dentist when performing any covered dental services allowed within such license.

ELIGIBILITY DATE: The first date of coverage after the Eligible Employee has enrolled. See **Eligibility & Enrollment** section.

FULL-TIME STUDENT: A dependent child attending an accredited or licensed institution of learning beyond high school, such as a college or university for the minimum number of credit hours required by that institution in order to maintain Full-Time Student status.

HEALTH CARE PROFESSIONAL: A Physician or other Health Care Professional licensed, accredited, or certified to perform specified health services consistent with State law.

INJURY: A bodily injury which results independently of illness and is caused by accidental means. All bodily injuries sustained in any one accident and all related conditions and recurrent symptoms will be considered one Injury.

LATE ENROLLEE: An Eligible Employee or Eligible Dependent who does not elect coverage under this Plan within thirty-one (31) days of their Eligibility Date. An employee not enrolled or not eligible for coverage under the Employer's previous Employer-sponsored plan will not be considered a Late Enrollee.

ORTHODONTIC TREATMENT: The corrective movement of teeth to treat a handicapping malocclusion of the mouth.

PLAN ADMINISTRATOR: The Employer, which is sponsoring this Plan for its employees. The Plan Administrator may hire persons or firms to process claims and perform other Plan connected services.

POST-SERVICE CLAIM: Post-Service Claims are all claims that are not Pre-Service Claims.

PRE-SERVICE CLAIM: Pre-Service Claims is any request for approval of a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

PREFERRED PROVIDER NETWORK: All participating providers, health professional, Hospitals, or other organizations having an agreement with the Preferred Provider Organization (PPO).

SPECIAL ENROLLEE: An Eligible Employee or Eligible Dependent who declined coverage under this Plan due to coverage under the spouse's employer sponsored plan, provided the employee enrolls under this Plan within thirty-one (31) days after termination of coverage under the spouse's employer-sponsored plan. A Special Enrollee is not considered a Late Enrollee.

TOTALLY DISABLED: An employee will be considered Totally Disabled during any period when, as a result of Injury or illness, the employee is completely unable to perform the duties of the employee's occupation and is unable to perform any other work or to engage in any other employment or occupation for wage or profit.

A dependent will be considered Totally Disabled during any period when, as a result of any Injury or illness, the dependent is unable to perform the normal activities of a person of like age and sex in good health.

URGENT CARE CLAIM: Any Pre-Service Claim for dental care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a Physician with knowledge of the Claimant's dental condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A Post-Service Claim is never an Urgent Care Claim.

USUAL AND CUSTOMARY CHARGE: Charges made for dental services or supplies essential to the care of the individual will be subject to a Usual and Customary determination. Usual and Customary allowances are based on what is usually and customarily accepted as payment for the same service within a geographical area. In determining whether charges are Usual and Customary allowances are based on what is usually and customarily accepted as payment for the same service within a geographical area. In determining whether charges are Usual and Customary, consideration will be given to the nature and severity of the condition and any dental complications or usual circumstances which require additional time, skill or experience.

TERMINATION OF BENEFITS

An employee's or dependent's coverage shall terminate at the earliest time indicated below:

1. In the event the employee fails to make any required contributions for their benefits when due, benefits shall automatically terminate at the end of the period for which the contribution was made.
2. Upon termination of employment or retirement, benefits will cease the last day of the month in which the employee terminated. Cessation of active work by an employee shall be deemed termination of employment, except as follows:
 - a. In the event an employee is absent on account of illness or Injury, employment shall be deemed to continue for the purpose of benefits hereunder until the date contributions received from the Employer for such employee's benefits are discontinued.
 - b. The benefits of an employee who is temporarily laid-off or granted leave of absence may be continued, but not beyond the end of the leave of absence or lay-off. The leave of absence or lay-off may not exceed six (6) months.
3. The date the employee or dependent ceases to be eligible for coverage or ceases to be in a class eligible for coverage.
4. When maximum benefits of this Plan have been exhausted.
5. The date the dependent becomes an Eligible Employee.
6. When the employee or dependent enters the military service on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year.
7. The date the Plan is terminated.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

An eligible employee is entitled to a maximum of twelve (12) weeks of unpaid leave in any twelve (12) month period for reasons that qualify under FMLA.

An employee may choose not to retain dental coverage during the FMLA leave. However, when an employee returns from leave, the employee is entitled to have coverage reinstated on the same basis as it would have been if the leave had not been taken. (Coverage will be reinstated without any additional qualification requirements imposed by the Plan. The Plan's provisions with respect to Deductibles and Co-insurance amounts will apply on the same basis as they did prior to the FMLA leave.)

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If an individual was covered under this Plan immediately prior to being called to active duty by any of the uniformed services of the United States of America, coverage may continue for up to eighteen (18) months or the period of uniformed service leave, whichever is shortest, if the individual pays any required contributions toward the cost of coverage during the leave. If the leave is less than thirty (30) days, the contribution date will be the same as for active employees. If the leave is longer than thirty (30) days, the required contribution will not exceed 102% of the cost of coverage.

Whether or not the individual elects continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA), coverage will be reinstated on the first day the individual returns to active employment with the Employer if released under honorable conditions and the individual returns to employment: (a) on the first full business day following completion of the military service for a leave of thirty (30) days or less; or (b) within fourteen (14) days of completing military service for a leave of thirty-one (31) to one hundred eighty (180) days; or (c) within ninety (90) days of completing military service for a leave of more than one hundred eighty (180) days (a reasonable amount of travel time or recovery time for an illness or injury determined by the VA to be service connected will be allowed).

When coverage under this Plan is reinstated, all provision and limitation of this Plan will apply to the extent that they would have applied if the military leave had not been taken and coverage had been continuous under this Plan. The pre-existing condition limitation will be credited as if you had been continuously covered under this Plan from the original effective date. (This waiver of limitations does not provide coverage for any Illness or Injury caused or aggravated by the military service, as determined by the VA. For complete information regarding the rights under USERRA contact the Employer.)

CONTINUATION OF BENEFITS (COBRA)

A Covered Person whose coverage has been terminated for any Qualifying Event enumerated below has the right to continue coverage for all benefits of this Plan if covered for such benefits on the day immediately preceding the termination date. A child born or placed for adoption with a Covered Employee during the continuation period will also be eligible for continuation of benefits.

The time period for which the continuation is available is indicated below in conjunction with the corresponding Qualifying Event.

If COBRA is elected, coverage will continue as though termination of employment or loss of eligible status has not occurred. Any accumulation of deductibles or benefits paid prior to termination or loss of eligibility, which had been credited toward any deductible or maximum benefit of this Plan, will be

retained. COBRA may not be denied to an individual who had coverage under another group health plan or Medicare prior to a Qualifying Event.

Also, no new pre-existing condition limitation requirements will apply. If any changes are made to the coverage for employees actively-at-work, the coverage provided to the individuals under this continuation provision will be similarly changed.

QUALIFYING EVENTS

An **eighteen (18) month** continuation is available to employees and/or dependents in the event of any one or both of the following Qualifying Events.

1. An employee's termination of employment for any reason, except gross misconduct;
2. An employee's loss of eligibility to participate due to reduced work hours.

In the even an employee and/or dependent has both qualifying events happen, the total length of the continuation will not exceed eighteen (18) months.

A **twenty-nine (29) month** continuation shall be available to all covered family members in the event a Covered Person is disabled on or before the date of the employee's Qualifying Event, or is disabled during the first sixty (60) days of the COBRA continuation.

The Covered Person must provide the Plan Administrator with notice of the disability within sixty (60) days of the determination of the disability and before the end of the original eighteen (18) month COBRA coverage period. The Covered Person must notify the Plan Administrator of a determination by Social Security that the individual is no longer disabled within thirty (30) days of such determination.

A Covered Person will be determined disabled per Social Security guidelines.

A **thirty-six (36) month** continuation shall be available to a dependent spouse and/or child in the event of any one of the following Qualifying Events:

1. An employee's death;
2. Divorce or legal separation from the employee;
3. A dependent child's loss of eligibility to participate;
4. A dependent's loss of eligibility to participate in this Plan due to the employee becoming entitled to Medicare benefits as a result a disability or choosing Medicare in place of this Plan at age sixty-five (65).

Individuals may be covered under multiple Qualifying Events, but in no case will coverage be continued for more than thirty-six (36) months.

NOTICE OF CONTINUATION

A Covered Person has sixty (60) days from the date of loss of coverage as a result of a Qualifying Event or sixty (60) days from the date the Plan Administrator notifies the Covered Person of their rights, whichever is longer, to elect coverage. The Plan Administrator will also notify the Covered Person of the cost of the continuation. (Payment of premium for the period from the date of loss of

coverage to election of continuation is not required until the forty-fifth (45th) day after the election). All payments for coverage after the date of election are subject to a thirty (30) day grace period.

If a Covered Person waives coverage under COBRA, and later re-elects coverage within the sixty (60) days, the Covered Person will be eligible to continue coverage under COBRA. However, coverage will not begin until the date of the revocation of the waiver.

The Covered Person is required to notify the Plan Administrator within sixty (60) days of any Qualifying Event that affects the eligibility of a dependent.

TERMINATION OF CONTINUATION OF COVERAGE

Continuation of Coverage shall not be provided beyond whichever of the following dates is first to occur:

1. The date the maximum continuation period expires for the corresponding Qualifying Event;
2. The date this Plan is terminated;
3. The date the individual fails to make the required contribution to continue coverage;
4. The date the individual becomes covered under any other group health plan after the date of COBRA election which does not contain any exclusion or limitation with respect to any pre-existing condition;
5. The date the individual has satisfied the pre-existing condition limitation of the group health plan the individual has become covered under after the date of Cobra election;
6. The date the individual becomes entitled to Medicare benefits after the date of COBRA election; or
7. In the month that begins more than thirty (30) days after a final determination has been made that an individual is no longer disabled.

COORDINATION OF BENEFITS

If a Covered Person is covered under more than one group plan as defined below, including this Plan, benefits will be coordinated. The benefits payable under this Plan for any Claim Determination Period, will be either its regular benefits or reduced benefits which, when added to the benefits of the other plan, may equal 100% of the Allowable Expenses defined below.

DEFINITIONS

Allowable Expenses: Any Medically Necessary, Usual and Customary item of expense incurred by a Covered Person which is covered at least in part under this Plan.

Claim Determination Period: A Calendar or Plan Year or that portion of a Calendar or Plan Year during which the Covered Person for whom the claim is made has been covered under this Plan.

Plan: Any plan under which dental benefits or services are provided by:

1. Group, blanket or franchise insurance coverage;
2. Any group Hospital service prepayment, group medical service prepayment, group practice or other group prepayment coverage;
3. Group coverage under labor-management trusted plans, union welfare plans, Employer organization plans or employee benefits plans;
4. Coverage under Medicare and any other governmental programs that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary.
5. Coverage provided through a school or other educational institution; or
6. Coverage under any Health Maintenance Organization (HMO).

ORDER OF BENEFIT DETERMINATION

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits paid by both plans will not exceed 100% of the Allowable Expenses. Neither plan pays more than it would without the Coordination of Benefits provision.

A plan without a Coordination of Benefits provision is always the primary plan. The FIRST rule that applies determines primary carrier and supersedes the following rules. If all plans have a Coordination of Benefits provision:

1. The plan covering the person directly, rather than as an employee's dependent, is primary and the other plans are secondary.
2. Dependent children of parents not separated or divorced, or unmarried parents living together: the plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second.

However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

3. Dependent children of separated or divorced parents, or unmarried parent not living together. When parents are separated or divorced or unmarried and not living together, neither the male/female nor the birthday rules apply. Instead:
 - a. The plan of the parent with custody pays first;
 - b. The plan of the spouse of the parent with custody (the step-parent) pays next;
 - c. The plan of the parent without custody pays next; and
 - d. The plan of the spouse of the non-custodial parent pays last.

However, if specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and the insurer or other entity obliged to pay or

provide the benefits of that parent's plan has actual knowledge of those terms, that plans pays first.

4. Active/Laid-Off or Retired Employees: The plan which covers that person as an active employee (or as that employee's dependent) determines its benefits before the Plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the Plan which covers that person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule (4) will not apply.
5. If a person whose coverage is provided under a right of continuation pursuant to state or federal law (i.e. COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (5) is ignored.
6. If none of the above rules determines the order of benefits, the plan covering a person longer pays first. The plan covering that person for the shorter time pays second.

Coordination of Benefits may operate to reduce the total amount of benefits otherwise payable during any Claim Determination Period with respect to a Covered Person under this Plan. When the benefits of this Plan are reduced, each benefit is reduced proportionately. The reduced amount is then charged against any applicable benefit limit of this Plan.

When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Allowable Expense and a benefit paid.

RECOVERY

If the amount of the payment made by this Plan is more than it should have been, the Contract Administrator on behalf of the Plan, has the right to recover the excess from one or more of the following:

1. The person this Plan has paid or for whom it has paid;
2. Providers of care;
3. Insurance companies; or
4. Other organizations.

PAYMENT TO OTHER CARRIERS

Whenever payments, which should have been made under this Plan in accordance with the above provisions, have been made, this Plan will have the right to pay any organization making those payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, this Plan will be fully discharged from liability.

SUBROGATION

Benefits are payable only upon the Covered Person's acceptance of the terms of the Plan. As a condition to receiving benefits under this Plan, a Covered Person agrees:

1. To serve as a constructive trustee, and to hold in constructive trust such money or property resulting from any payments or settlement proceeds and agrees that they will not dissipate any such money or property without prior written consent of the Plan, regardless of how such money or property is classified or characterized, from any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, other insurance policies for funds; and
2. To restore to the Plan any such benefits paid or payable to, or on behalf of the Covered Person when said benefits are paid or established by any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, other insurance policies for funds; and
3. To refrain from releasing any party, person, corporation, entity, insurance company, insurance policies or funds that may be liable for or obligated to the Covered Person for the Injury or condition without obtaining the Plan's written approval; and
4. Without limiting the preceding, to subrogate the Plan to any and all claims, causes of action or rights that they have or that may arise against any person, corporation and/or other entity and to any coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, other insurance policies or funds ("Coverage") for which the Covered Person claims an entitlement to benefits under this Plan, regardless of how classified or characterized.

In the event a Covered Person settles, recovers, receives, or is reimbursed by any third party or Coverage, the Covered Person agrees that they are a constructive trustee, and shall hold any such funds received in constructive trust for the benefit of the Plan, and to transfer title to the Plan for all benefits paid or that will be paid as a result of said Injury or condition. The Covered Person acknowledges that the reimbursement, and that the Plan's subrogation rights shall be considered a first priority claim and shall be paid before any other claims for the Covered Person as the result of the Illness or Injury, regardless of whether the Covered Person is made whole. If the Covered Person fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any recovery or reimbursement received, the Covered Person will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

The Covered Person shall execute and return a Subrogation Agreement to the Plan Administrator and shall supply other reasonable information and assistance as requested by the Plan Administrator regarding the claim or potential claim. If the Subrogation Agreement is not executed and returned or if information and assistance is not provided to the Plan Administrator upon request, no benefits will be payable under the Plan with respect to costs incurred in connection with such Illness or Injury.

If the Covered Person (or guardian or estate) decides to pursue a third party or any Coverage available to them as a result of the said Injury or condition, the Covered Person agrees to include the Plan's subrogation claim in that action and if there is failure to do so the Plan will be legally presumed to be included in such action or recovery. In the event the Covered Person decides not to pursue any and all third parties of Coverage, the Covered Person authorizes the Plan to pursue, sue, compromise or settle any such claims in their name, and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person (or guardian or estate) agrees to take no prejudicial actions against the subrogation rights of the Plan or to in any way impede the action taken by the Plan to recover its subrogation claim. Such cooperation shall include a duty to provide information, execute

and deliver any acknowledgment and other legal instruments documenting the Plan's subrogation rights and take such action as requested by the Plan to secure the subrogation rights of the Plan.

The Plan will not pay or be responsible, without its written consent, for any fees or cost associated with a Covered Person pursuing a claim against any Coverage or third party. The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of the Plan document. The Plan Administrator may amend the Plan in its sole discretion at anytime without notice. This right of subrogation shall bind the Covered Person's guardian(s), estate, executor, person representative, and heir(s).

RIGHTS OF RECOVERY

In the event of any overpayment of benefits by this Plan, the Plan will have the right to recover the overpayment. If a Covered Person is paid a benefit greater than allowed in accordance with the provisions of this Plan, the Covered Person will be requested to refund the overpayment. If payment is made on behalf of a Covered Person to a Hospital, Physician or other provider of health care, and that payment is found to be overpayment, the Plan will request a refund of the overpayment from the provider first. If the provider does not honor the Plan's request for a refund, the Plan will then request the overpayment from the Covered Person. If the refund is not received from the provider or Covered Person, the amount of the overpayment will be deducted from future benefits.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of implementing the terms of this Plan, the Contract Administrator retains the right to request any dental information from any insurance company or provider of service it deems necessary to properly process a claim. The Contract Administrator may without consent of the Covered Person, release or obtain any information it deems necessary. Any person claiming benefits under this Plan shall furnish to the Contract Administrator such information as may be necessary to implement this provision.

REIMBURSEMENT RIGHTS

The Covered Person, by accepting benefits under this Plan, agrees to hold in constructive trust any money or property resulting from any recovery, insurance payments or settlement proceeds, third party payments, settlement proceeds or judgment for the Plan's benefits under this provision. If a Covered Person fails to reimburse the Plan for all benefits paid or to be paid, as a result of their Illness or Injury, out of any recovery or reimbursement received, the Covered Person will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person. This right of reimbursement shall bind the Covered Person's guardian(s), estate, executor, personal representative, and heir(s).

RIGHTS OF COVERED EMPLOYEES (ERISA)

As a participant in this Plan, Covered Persons are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT THE PLAN AND BENEFITS

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health coverage for the employee, the employee's spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. The employee or the employee's dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if the Covered Person has creditable coverage from another plan. A Covered Person should be provided a certificate of creditable coverage, free of charge, from the group health plan or health insurance issuer when the Covered Person loses coverage under the Plan, when the Covered Person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if the Covered Person requests it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, a Covered Person may be subject to a pre-existing condition exclusion for twelve (12) months (18 months for Late Enrollees) after the Covered Person's enrollment date for coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all plan participants and beneficiaries. No one, including the Employer, a union, or any other person, may fire the employee or otherwise discriminate against the employee in any way to prevent the employee from obtaining a welfare benefit or exercising a Covered Person's rights under ERISA.

ENFORCEMENT OF RIGHTS

If a claim for a welfare benefit is denied or ignored, in whole or in part, a Covered Person has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps a Covered Person can take to enforce the above rights. For instance, if a Covered Person requests a copy of plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, a Covered Person may file suit in Federal Court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$110 a day until the Covered Person receives the material, unless the materials were not sent because of reasons beyond the control of the administrator. If a Covered Person has a claim for benefits which is denied or ignored, in whole or in part, a Covered Person may file suit in a state or Federal Court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, a Covered Person may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if the Covered Person is discriminated against for asserting their rights, the Covered Person may seek assistance from the U.S. Department of Labor, or the Covered Person may file suit

in a Federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful the court may order the person the Covered Person sued to pay these costs and fees. If a Covered Person loses, the court may order the Covered Person to pay these costs and fees, for example, if it finds the claim is frivolous.

ASSISTANCE WITH QUESTIONS

If a Covered Person has any questions about the Plan, the Covered Person should contact the Plan Administrator. If a Covered Person has any question about this statement or about the Covered Person's rights under ERISA, or if the Covered Person needs assistance in obtaining documents from the Plan Administrator, the Covered Person should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 20 Constitution Avenue N.W., Washington, D.C. 20210. A Covered Person may also obtain certain publications about their rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

GENERAL PROVISIONS

NOTICE OF CLAIM

Written notice of a claim and all information needed to process the claim must be given to the Contract Administrator as soon as reasonably possible and in no event, later than one year from the date such claim is incurred.

RECORDS

For the purposes of claims administration, each Covered Person authorizes and directs any provider that has attended, examined or treated them, to furnish to the Contract Administrator, at any time upon its request, any and all information, records or copies or records relating to the attendance, examination or treatment rendered to the Covered Person; and the Contract Administrator agrees that such information and records will be considered confidential. Further, any charges imposed relative to the acquisition of such information will be absorbed by the Covered Person.

CLAIM DETERMINATION

Urgent Care Claims:

Determination for Urgent Care Claims (whether adverse or not) must take place as soon as possible but not longer than seventy-two (72) hours, unless the Claimant fails to provide sufficient information to determine whether, or to what extent benefits are covered or payable under the Plan. In the case of such failure, the Contract Administrator shall notify the Claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Contract Administrator shall notify the Claimant of the Plan's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

1. The Plan's receipt of the specified information; or
2. The end of the period afforded the Claimant to provide the additional information.

Urgent Care Claims must be decided within seventy-two (72) hours. There is no extension of time allowed for claims involving urgent care.

Pre-Service Claims:

Pre-Service Claims must be decided within a maximum of fifteen (15) days at the initial level and up to thirty (30) days following an Adverse Benefit Determination. In the case of a failure by a Claimant or an Authorized Representative of a Claimant to follow the Plan's procedures for filing a Pre-Service Claim, the claim or representative shall be notified of the failure and the proper procedures to be followed in filing a Claim for Benefits. This notification shall be provided to the Claimant or Authorized Representative, as appropriate, as soon as possible, but not later than five (5) days following the failure. Notification may be oral, unless written notification is requested by the Claimant or Authorized Representative.

Post-Service Claims:

Post-Service Claims must be decided within thirty (30) days for the initial decision and a maximum of sixty (60) days on review.

Filing Extensions:

The Plan may extend determination on both pre-service and Post-Service Claims for one additional period of fifteen (15) days after expiration of the relevant initial period, if the Contract Administrator determines that such an extension is necessary for reasons beyond the control of the Plan. Delays caused by cyclical or seasonal fluctuations in claims volume are not considered to be matters beyond the control of the Plan that would justify an extension.

If the reason for taking the extension is the failure of the Claimant to provide necessary information, the time period for making the determination is tolled from the date on which notice of the necessary information is sent to the Claimant until the date on which the Claimant responds to the notice. The time periods for making a decision are considered to commence to run when a claim is filed in accordance with the reasonable filing procedures of the Plan, without regard to whether all the information necessary to decide the claim accompanies the filing.

Concurrent Care Decisions:

If a Plan has approved an ongoing course of treatment to be provided over a period of time, or number of treatments, any reduction or termination by the Plan (other than by plan amendments or termination) before the end of such period of time or number of treatments shall be considered an Adverse Benefit Determination. The Contract Administrator shall notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

Any requests by a Claimant to extend the course of treatment beyond the period of time or number of treatments for a claim involving urgent care, shall be decided as soon as possible, taking into account the dental exigencies, and the Contract Administrator shall notify the Claimant of the benefit

determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

Adverse Benefit Determination:

The notice of an Adverse Benefit Determination will either include the protocol in which it was based upon or a statement that a protocol was relied upon and that a copy is available free of charge upon request by the Claimant.

Notification of an Adverse Benefit Determination (at both the initial level and on review) based on medical necessity, experimental treatment, or other similar exclusion or limit will be explained as to the scientific or clinical judgment of the Plan to the Claimant's dental circumstances, or an explanation will be provided free of charge to the Claimant upon request.

Where the Plan utilizes a specific internal rule or protocol, it must furnish the protocol to the Claimant or their Authorized Representative upon request.

Authorized Representative:

The Plan will recognize an Authorized Representative, including a health care provider, acting on behalf of a Claimant. The Plan will recognize a Health Care Professional with knowledge of a Claimant's dental condition as the Claimant's representative in connection with an Urgent Care Claim. Procedures will be established by the Plan for verifying that an individual has been authorized to act on behalf of a Claimant.

RIGHT OF REVIEW AND APPEAL

A Claimant has up to one hundred eighty (180) days to file an appeal of an Adverse Benefit Determination. As part of the appeal process, a Covered Person has the right to (a) review this Plan and other relevant documents, (b) argue against the denial in writing, and (c) have a representative act on behalf of the Covered Person in the appeal. All relevant documents will be provided free of charge, upon request by the Claimant, after receiving an Adverse Benefit Determination. A document, record or other information is considered relevant if it was relied upon in making the benefit determination, if it was considered or generated in the course of making the benefit determination, if it demonstrated compliance with the administrative processes, or if it constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the determination.

If the Claimant or an Authorized Representative appeals an Adverse Benefit Determination, the Contract Administrator will respond to the appeal within seventy-two (72) hours for an Urgent Care Claim, thirty (30) days for a Pre-Service Claim, and sixty (60) days for a Pose-Service Claim. The notice will specify the reason for the denial or describe the additional information required to process the claim. Written denial will include:

1. Specific reasons for denial with reference to the Plan Document section(s);
2. A description and need for any other material pertinent to the claim; and
3. An explanation of this Plan's review procedure and the names of any medical professionals consulted as part of the claims process.

A full and fair review of an Adverse Benefit Determination will be performed by an appropriate named fiduciary, who is neither the party who made the initial adverse determination, nor the subordinate of such person. The review will not defer to the initial Adverse Benefit Determination. The review will take into account all comments, documents, records and other information submitted by the Claimant, without regard to whether such information was previously submitted or considered in the initial determination.

If the review results in another Adverse Benefit Determination, it shall include specific reasons for denial, written in a manner understandable to the Covered Person, and will contain specific reference to the pertinent Plan provisions upon which the decision was based.

A Covered Person must follow the Right of Review and Appeal procedures listed above before initiating any legal actions. This is the Covered Person's administrative remedies, which must be exhausted before legal action may be pursued.

If the Plan fails to provide procedures in compliance with the regulation, or the required procedures, the Claimant is deemed to have exhausted the administrative remedies and is free to pursue legal action as provided in ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

PLAN INTERPRETATION

All decisions concerning the interpretation or the application of this Plan and its terms, shall be at the discretion of the Plan Administrator.

PERIODIC REPORT

Within one month following the date of any change in the group of employees and dependents covered, the Employer shall furnish the Contract Administrator the names of all employees who have become covered or cease to be covered since the date of the previous reports.

Failure on the part of the Employer to report the name of any employees or dependents who are eligible for coverage, shall not deprive such persons of their benefits under the Plan; nor shall failure on the part of the Employer to report any termination of any employee or dependent, obligate the Plan to continue such benefits beyond the date of termination.

CHOICE OF DENTIST

The Covered Person shall have the free choice of any Dentist and the Dentist-patient relationship shall be maintained.

AFFILIATED COMPANIES

Any of the Employer's affiliates, subsidiaries or divisions may be deleted or added to the Plan upon written notice by the Employer on or before the date such deletion or addition is effective.

EMPLOYEE CONTRIBUTION

Participation in this Plan is entirely voluntary. The Employer reserves the right to modify the amount of any employee contributions.

INSPECTION OF PLAN DOCUMENT

The Employer upon request, shall make this Plan Document available to inspection by any Covered Person at a reasonably accessible place.

AMENDMENT OR TERMINATION OF THE PLAN

The Plan may be amended or terminated at any time without prior notice and, except as otherwise provided, in any manner, by written authorization and signed by one of the following officers of the Company: Chief Executive Officer, Chief Financial Officer, President, Vice President, or by any other officer to whom the Company's Board of Directors delegates the authority to amend the Plan.

It is the intent of this Plan to comply with all applicable Federal and State laws. Wherever this Plan is in conflict with such state law, the law will prevail, unless exempt under federal law.

INSTRUCTIONS FOR SUBMISSION OF CLAIMS

Be sure the bills submitted include all of the following:

1. Employee's name, social security number and home address.
2. If claim is made for a dependent, name, employer and age.
3. Employer's name and group number.
4. Name and address of the Dentist.
5. Dentist's diagnosis.
6. Itemization of charges.
7. Date the injury or illness began.
8. Drug bills (not cash register receipts) showing RX number, name of drug, date prescribed, and name of person for whom drug is prescribed.

Claims Processing Procedures:

Acceptable bills/documents:

1. HCFA/UB; or
2. Superbills – any submitted claim form with all of the following information:
 - a. Detail of procedure performed
 - b. Detailed breakdown of charges
 - c. Diagnosis
 - d. Date of service
 - e. Federal Tax Identification Number (TIN) and address of provider

A billing submitted with all of the above information included will be processed, unless additional information is required to complete a claim. Additional information required may include, but is not limited to the following:

1. Coordination of Benefits – Other Insurance Coverage
2. COBRA eligibility
3. Parental custody
4. Legal responsibility for dependent child health coverage
5. Divorce decree
6. Medicare eligibility
7. Full-Time Student status

8. Medical/dental history information
9. Injury or accident information.

When the Contract Administrator receives a billing with the required information, the Contract Administrator will process it in accordance with the time frames for Post-Service Claims, Pre-Service Claims and Urgent Care Claims, and in accordance with all other Plan provisions, and in accordance with eligibility and claim information file. The Contract Administrator will provide a notice of benefit determination or a notice of Adverse Benefit Determination to the Covered Person's designated address.

Please direct all claims and questions regarding claims to:

Formula Corporation
3265 Northwood Circle, Suite 170
Eagan, MN 55121-4203
(651)686-0108
Toll Free (888)686-0412

Every attempt will be made to help Covered Persons understand their benefits; however, any statement made by an employee of the Employer or the Contract Administrator will be deemed a representation and not a warranty. Actual benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing.

If a definite answer to a specific question is required, please submit a written request, including all pertinent information, and a statement from the attending Physician (if applicable), and a written reply (which will be kept on file) will be sent.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section 1 – USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

This Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

2. Determination of eligibility,
3. Coverage and Cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);
4. Coordination of Benefits;
5. Adjudication of health benefit claims (including appeals and other payment disputes);
6. Establishing employee contributions;

7. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
8. Billing, collection activities and related health care data processing;
9. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
10. Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);
11. Medical necessity reviews or reviews of appropriateness of care or justification of charges;
12. Utilization review, including pre-authorization, concurrent review and retrospective review;
13. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security Number, payment history, account number and name and address of the provider and/or health plan) and;
14. Reimbursement to the Plan.

Health care operations include, but are not limited to, the following activities:

1. Quality assessment;
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with full information about treatment alternatives and related functions;
3. Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
5. Conducting or arranging for dental review, legal services and auditing functions including fraud and abuse detection and compliance programs;
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies.
7. Business management and general administrative activities of the Plan, including, but not limited to:

- a. Management activities relating to the implementation of and compliance with HIPPA's administrative simplification requirements; or
 - b. Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
- 8. Resolution of internal grievances; and
 - 9. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPPA or, following completion of the sale or transfer, will become a covered entity.

SECTION 2 – THE PLAN WILL USE AND DISCLOSE PHI AS REQUIRED BY LAW AND AS PERMITTED BY AUTHORIZATION OF THE PARTICIPANT OR BENEFICIARY

With an authorization, the Plan will disclose PHI to the benefit plans or other separate plans of this Employer.

SECTION 3 – FOR PURPOSES OF THIS SECTION, THE EMPLOYER IS THE PLAN SPONSOR

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions.

SECTION 4 – WITH RESPECT TO PHI, THE PLAN SPONSOR AGREES TO CERTAIN CONDITIONS

The Plan Sponsor agrees to:

- 1. Not use or further disclose PHI other than as permitted or required by the plan document or as required by law;
- 2. Ensure that any agents, including a subcontractor and the Contract Administrator, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- 3. Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- 4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- 5. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- 6. Make PHI available to an individual in accordance with HIPAAS's access requirements;
- 7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- 8. Make available the information required to provide an account of disclosures;

9. Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the plan's compliance with HIPAA; and
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such 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).

SECTION 5 – ADEQUATE SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR MUST BE MAINTAINED

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

1. The benefits manager; and/or
2. Staff designated by the Benefits Manager.

SECTION 6 – LIMITATIONS OF PHI ACCESS AND DISCLOSURE

The persons described in Section 5 may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan.

SECTION 7 – NONCOMPLIANCE ISSUES

If the persons described in Section 5 do not comply with this plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

We hereby agree that this Summary Plan Description is in compliance with the requirements as set forth by Northwestern Health Sciences University

DATED THIS _____ DAY OF _____, 2004.

NORTHWESTERN HEALTH SCIENCES UNIVERSITY

By _____

Its _____

FORMULA DENTAL

By _____

Its _____

