OASIS Trust
SINCE 1969

Employee Dental Plan Summary Booklet

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SCHEDULE OF BENEFITS

This Summary booklet does not apply unless the following information is completed indicating the participating Employer name and the particular benefit provisions that apply to your group.

General Information

Participating Employer Name: Mayfield City School District

Plan Year: January 1st — December 31st

Enrollment & Eligibility Information

Eligible Employee: Full time

Applicable Waiting Period for Enrollment: None

Dependent and Full-Time Student Majority Age: Dependents are covered to the end of the month that they turn 26, regardless of Student status.

Child as Dependent of One or Both Parents: One

Coordination of Benefits (Husband/Wife Combination): Maintenance of benefits, Birthday rule, no husband/wife combination

Reasons for Termination of Coverage: (standard benefits unless otherwise stated within)

SCHEDULE OF BENEFITS CONT.

Benefit Information

Single Deductible: $25

Family Deductible: $50

Coinsurance Amounts: Class I 100%, Class II 80%, Class III 80%, Class IV 60%

Maximum Benefit: $3,000 Calendar Year (Class I, II, III) $1,750 Lifetime (Class IV)

Dental Benefit as Percentage of Reasonable and Customary: 90%

Available Dental Services: (standard benefits unless otherwise stated within)

X-ray Limits: Bitewings as needed, Full Mouth or Panoramic limited to 1 in 36 consecutive months

Fluoride Application Limits: 1 in 12 consecutive months, no age limit

Scaling and Root Planing Limits: 1 in 24 consecutive months

Rebasing and Relining of Dentures Limits: Must be after 6 months of initial installation

Adult Orthodontia: Yes

Limitations, Exclusions and any Other Specific Provisions: (standard benefits unless otherwise stated within)

Family Security Benefit: 2 years

Dental Network(s): Aetna Dental, Dentemax, Novanet Dental

INTRODUCTION

Your **Employer** is a participating **Employer** in the OASIS Trust Employee Dental Plan, which is set up to provide dental benefits to Employees of participating **Employers**. The benefits are paid from the funds of the **OASIS Trust**, and not by an insurer. Any contributions from **Participants** are deposited directly in the **Trust**. All funds received by the **Trust** shall be applied toward the payment of claims and reasonable **Plan** administration expenses.

The Administrative Committee of the **Trust**, who has overall responsibility for the administration of the **Plan**, has retained the services of an independent **Claims Processor**, Luminare Health Benefits, Inc. to provide technical services, including the administration of claims payment.

To be a **Participant** under the terms of the **Plan**, you must be an eligible **Employee** as defined by your **Employer**, have completed the necessary enrollment forms, and if required to do so, contribute to the cost of the **Plan.**

DEFINITIONS

Terms in this Summary that are capitalized and in bold print have special meanings that are listed below.

Administrator – means the Administrative Committee of the **OASIS Trust**.

Child or Children – as used in the definition of **Dependent**, means only (1) biological **Children**, (2) pre-adopted **Children** (provided you have assumed custody of and have formally applied for the adoption of such **Children**), (3) adopted **Children**, (4) stepchildren, and (5) unmarried **Children** provided that (a) the **Child** has not reached the maximum age(s) listed in the **Schedule of Benefits**, (b) the **Child** has never been married and (c) you or your spouse are the **Child's** legal guardian.

A **Child** may also include any **Child** who is recognized by a Court order or a Qualified Medical Child Support Order (QMCSO) as being entitled to coverage under the **Plan**, even if the **Child** does not live with you. You may request a copy, free of charge, of the additional information and process for determining the qualification of a QMCSO from the **Claims Processor.**

Children who are **Full-time Students** beyond the age limit in the **Schedule of Benefits** and disabled Children may also qualify for coverage. Contact the **Claims Processor** for additional details.

Claims Processor – means Luminare Health Benefits, Inc.. See the first page of this Summary for contact information.

Close Relative – means an **Employee's** spouse, **Children**, brothers, sisters or parents, or the **Children**, brothers, sisters or parents of the **Employee's** spouse.

Coinsurance – means the benefit percentage of **Covered Expenses** paid by the **Plan** as listed in the **Schedule of Benefits**. The **Coinsurance** is applied to **Covered Expenses** after your **Deductible**, if any, is met.

Covered Expenses – means **Medically Necessary** services, supplies or treatments that are recommended or provided by a **Dentist** or other professional provider for the treatment of a dental condition and that are not specifically excluded for coverage in this Summary or the **Schedule of Benefits**.

Deductible – means the amount that you must pay before the **Plan** pays benefits. The **Deductible** does not apply to all Classes of Benefits. See the **Deductible** section below for additional information.

Dentist – means an individual who is a licensed doctor of dental medicine (D.M.D.) or a licensed doctor of dental surgery (D.D.S.) in the state where the dental service is performed and who is operating within the scope of his license, other than a **Close Relative** of the **Participant**.

For the purpose of this definition, a medical physician will be considered to be a **Dentist** when he performs any of the dental services described in the **Schedule of Benefits**, and is operating within the scope of his license.

Dependent – means your:

(1) spouse,

(2) unmarried **Children** from birth up to the maximum age limit listed in the **Schedule of Benefits**,

(3) unmarried **Children** to the **Full-time Student** age limit listed in the **Schedule of Benefits** who are **Full-time Students** at a school, college, or university and who are dependent on you or your spouse for support, or

(4) unmarried **Dependent Children** over the applicable ages listed in the **Schedule of Benefits** who became physically or mentally incapable of self-support prior to the above ages, whose disability commenced while meeting the requirements of (2) or (3) above, and who are expected to be prevented from becoming self-supporting. Such **Child** will be considered a **Dependent** only if you submit proof of the **Child's** total disability to Luminare Health. Luminare Health reserves the right to require, at any time, proof of the continuation of such disability.

If an unmarried **Child** ceases to qualify as a **Dependent,** he may again become an eligible **Dependent** only as provided below:

(A) if you provide proof that the **Child** became physically or mentally incapable of self-support prior to the age limits specified in (2) or (3) above and met the requirements of (2) or (3) above and met such requirements for a period of 90 consecutive days, the **Child** will become an eligible **Dependent** as of the date he became physically or mentally incapable of support.

(B) if the **Child** becomes ineligible because he is no longer principally dependent upon you (or your spouse), he will become an eligible **Dependent**, provided he is under the age specified in (2) above either after he has been continuously principally dependent upon and has lived with you for a period of 90 consecutive days, or on the day he becomes enrolled as a **Full-time Student** in a school, college or university, whichever occurs earlier.

"Principally dependent upon" means dependent on you for support and maintenance as defined by the Internal Revenue Code. You must declare the **Dependent** as an income tax deduction unless a relevant Court document governing the **Child's** status as a **Dependent** (such as a divorce decree or QMCSO) provides otherwise. The **Claims Processor** may require proof of dependency, such as birth certificates, tax records or Court documents.

"Disabled Child" means a **Child** who is unmarried, incapable of self-sustaining employment and dependent on you for support due to a mental and/or physical disability, who was covered under the **Plan** prior to reaching the maximum age limit as listed in the **Schedule of Benefits** and who is expected to be prevented from becoming self-supporting.

Employee – means an eligible **Employee** as determined by the **Employer** and defined in the **Schedule of Benefits**. **"Employee"** does not include independent contractors, consultants, leased employees or persons covered by a collective bargaining agreement, unless the bargaining agreement provides for participation in the **Plan**.

Employer – means an **Employer** engaged in the field of education who has elected to become a participating **Employer** in the **OASIS Trust**.

Experimental/Investigational – means a dental service, supply and/or treatment that does not constitute accepted dental practice under the standards of the patient's case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the dental community or government oversight agencies at the time the service was rendered.

Family – means the **Employee** and his covered **Dependents**.

Full-time Student – means an **Employee's Dependent Child** who is enrolled in and regularly attending secondary school, an accredited college, university or institution of higher learning for the minimum number of credit hours required by that institution in order to maintain **Full-time Student** status. It is your responsibility to notify the **Claims Processor** of **Full-time Student** Status. Also, you must notify your **Employer** when your **Dependent** is no longer a **Full-time Student**.

Incur or Incurred – means with respect to a **Covered Expense**, the date the service, supplies or treatment are provided.

Medically Necessary (Medical Necessity) – means a service, supply or treatment which, as determined by the **Administrator**, or its designee, is:

(1) Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of your illness or injury and which could not be omitted without adversely affecting your condition or the quality of care rendered;

(2) In accordance with current standards of good dental practice within the organized dental community and is medically proven to be an effective treatment of your illness or injury; and

(3) The most appropriate supply or level of service that can safely be provided to you.

A service, supply or treatment will not be **Medically Necessary** if it is provided only as a convenience to you or your **Dentist**, or is part of a plan of treatment that is **Experimental/Investigational**, unproven or related to a research protocol.

The fact that your **Dentist** may prescribe, order, recommend, perform or approve a service, supply or treatment does not, by itself, make the service, supply or treatment **Medically Necessary.** In deciding whether a service, supply or treatment is **Medically Necessary**, the **Claims Processor**, or its designee, may request and rely on the opinion of a **Dentist** or **Dentists**. The determination of the **Claims Processor** is final and binding.

OASIS Trust or Trust – means the fund or trust established to hold contributions made by the participating **Employer** and **Participants** and to fund the payment of eligible benefit claims as determined by the **Claims Processor**.

Participant – means any eligible **Employee** who has satisfied the eligibility conditions listed in the **Schedule of Benefits** and participates in the **Plan**, as well as such **Employee's Dependents** who are enrolled in and covered under the **Plan**, when required for a reasonable interpretation of the **Plan's** provisions.

Plan – means the benefits and provisions for payment of benefits described in the OASIS Trust Employee Dental Plan.

Reasonable and Customary – means the amount of a **Covered Expense** that will be considered for payment under the **Plan**. A charged amount for a service, supply or treatment will be considered **Reasonable and Customary** if:

(1) it is the amount normally charged by the provider for similar services; and

(2) it does not exceed the amounts ordinarily charged by most providers of comparable services in the locality where the services are received.

In determining whether charges are **Reasonable and Customary**, consideration will be given to the nature and severity of the condition being treated and any complication or unusual circumstances requiring additional time, skill, or experience.

Schedule of Benefits – means the specific terms and provisions that apply to you as a **Participant** in the **Plan**. The **Schedule of Benefits** is listed in the front of this Summary.

WHO IS ELIGIBLE

When your **Employer** elects to participate in the OASIS Trust Employee Dental Plan, eligible classes of **Employees** are defined in the participation agreement. If you are in a class of eligible **Employees** defined in the **Schedule of Benefits**, you are eligible for coverage under the Plan. The **Schedule of Benefits** will also indicate if benefits are provided for your eligible **Dependents**. When **Dependents** are covered, those eligible will include:

(1) Your legal spouse; and

(2) Your unmarried **Dependent Children** as defined in the **Schedule of Benefits**.

ENROLLMENT & EFFECTIVE DATE

Enrollment. Before any benefit payments can be processed, you must complete and sign an enrollment form and/or complete the online enrollment process designated by your employer. You become eligible for coverage on the date you begin working in an eligible class of **Employees** as defined in the **Schedule of Benefits**. If you apply for coverage within 30 days of becoming eligible for coverage, your coverage will be effective on the day you complete the waiting period, if any, as defined in the **Schedule of Benefits**. If you apply more than 30 days after the date of becoming eligible, your coverage will not be effective until the next open enrollment period, if any, as defined in the **Schedule of Benefits**.

If you reject the coverage, you and your **Dependents** will not be covered.

New Enrollment. If you are a new **Employee**, you will be covered on your date of hire, or after completion of the waiting period, if any, as stated in the **Schedule of Benefits**, provided you have completed a dental enrollment form and/or completed the online enrollment process designed by your **employer**, and your Employer makes the required contribution.

Dependent Enrollment. Coverage for your **Dependents** will become effective on the later of the following events, provided you are also covered on that day;

(1) the date you are covered under the **Plan**;

(2) the date you acquire a new **Dependent**, provided you apply for **Dependent** coverage within 30 days of the date the **Dependent** was acquired and any required contributions are made, or

(3) the date a **Child** under 18 is placed with you for adoption. A **Child** is "placed for adoption" on the date you assume a legal obligation for the total or partial financial support of the **Child** during the adoption process. **Dependents** must be added to the coverage within 30 days of their eligibility date.

Late Enrollment. If you reject coverage under the **Plan** or voluntarily terminate your coverage while still employed, and subsequently desire to enroll in the **Plan**, you may do so only during an open enrollment period, if any, established by the **Employer** and stated in the **Schedule of Benefits**. Coverage will be effective on a date following the open enrollment period specified by the **Employer** and defined in the **Schedule of Benefits**.

Coverage During a Leave of Absence. If you are absent from work for any approved paid leave of absence, your participation in the **Plan** will continue and your contributions, if any, will continue to be deducted from your paycheck(s) during the leave of absence.

If you are absent from work for any approved unpaid leave of absence, you may continue to participate in the **Plan** during your leave provided that you continue to make any required contributions.

If you are absent from work due to an approved leave under the Family and Medical Leave Act of 1993 (FMLA), you may continue to participate in the **Plan** as though you were still an active **Employee**. If you drop coverage while you are on FMLA leave, you may reenter the **Plan** when you return to work, provided you apply for coverage within 30 days of returning to work. Contact your **Employer** for more details and to make arrangements to pay for your coverage, if required, during your leave.

If you are absent from work for a military leave, you may have certain rights to continue your dental coverage under the **Plan** while you are on leave. Contact your **Employer** or the **Claims Processor** for more information. Also, see the section of this Summary titled USERRA Continuation Coverage.

Rehired Employees. If you terminate employment with your **Employer** and you are later rehired by the same **Employer**, you may become a **Participant** in the **Plan** upon your reemployment, subject to the following rules:

(1) If you terminate employment prior to becoming a **Participant** and you are later rehired by the **Employer,** you must satisfy the eligibility requirements, if any, as specified in the **Schedule of Benefits**, in order to participate in the **Plan** without regard to any prior period of employment with the **Employer**.

(2) If you terminate employment after becoming a **Participant** and you are later rehired by the **Employer** within 30 or fewer days from the date you terminated employment, and you contribute toward your coverage on a pre-tax basis, you will automatically participate immediately in the **Plan** upon reemployment at the same level of coverage as in effect before your termination of employment, unless a change is otherwise permitted due to a qualified change in status.

(3) If you terminate employment after becoming a **Participant** and you are later rehired by the **Employer** more than 30 days from the date you terminated employment, you may participate in the **Plan** again upon reemployment when you again meet the **Plan's** eligibility requirements, if any, as stated in the **Schedule of Benefits.**

DEDUCTIBLE

Dental services and **Covered Expenses** are divided into Classes I through IV. There is no **Deductible** amount for Class I and IV services. Services in Classes II and III are subject to a **Deductible**, as listed in the **Schedule of Benefits.**

Individual Deductible. For Class II and III services, the **Deductible** listed in the **Schedule of Benefits** will be applied to each individual's **Covered Expenses** once each Plan Year as defined in the **Schedule of Benefits**. Once this **Deductible** has been satisfied, any further covered Class II or III services **Incurred** by that same person in that Plan Year will be paid in accordance with the **Schedule of Benefits.**

Family Deductible. When multiple individuals in a **Family Incur Covered Expenses** during the same Plan Year, and the total expenses used toward satisfying their **Individual Deductibles** is at least equal to the **Family Deductible**, if any, shown in the **Schedule of Benefits**, no further **Deductible** amounts are required for the balance of the Plan Year.

Carry-Over Provision. Any amounts for expenses **Incurred** in the last three months of a Plan Year which are applied toward a **Deductible** in that Plan Year, will be carried over and used toward satisfying the **Deductible** of the following Plan Year. If this benefit is elected by **Employer**.

COVERED EXPENSES

Covered Expenses include charges for the services listed in the Summary of Your Dental Plan Benefits. All dental services must be performed by or under the direction of a **Dentist**, and begin while you or your eligible **Dependent** are covered under the **Plan**.

No payment will be made for any dental services not provided for in the Summary of Your Dental Plan Benefits unless your **Employer** agrees to accept such services as a **Covered Expense**. If such services are accepted for payment, the amount will be determined by Luminare Health consistent with the allowances for other services listed in the Summary of Your Dental Plan Benefits.

Certain services have limitations on the frequency with which they are recognized as **Covered Expenses**. These limitations are noted in the **Schedule of Benefits.**

The **Plan** will pay the lesser of a percentage of the **Dentist's** actual charge or a percentage of the **Reasonable and Customary** fee charged for **Covered Expenses,** or if the dentist is a network provider, a percentage of the discounted charge. If network provider percentage of the discounted charge. The applicable percentages are indicated in the **Schedule of Benefits.** All **Covered Expenses** are subject to the **Plan's** limitations and exclusions and any specific provision listed in the **Schedule of Benefits.**

MAXIMUM BENEFITS

Class I, II and III expenses combined are subject to maximum benefit amount payable, per person, per Plan Year, as shown in the **Schedule of Benefits.**

Orthodontic expenses (Class IV) are subject to a lifetime maximum amount payable, per person, as shown in the **Schedule of Benefits.**

COORDINATION OF BENEFITS

If you or any one of your **Dependents** are covered under more than one Plan, benefits payable from all such Plans will be coordinated.

Coordination of Benefits will be used to determine the benefits payable for a person for any Claim Determination Period if, for the Allowable Expenses **Incurred** in that Period, the sum of:

(1) the benefits that would be payable from this **Plan** in the absence of coordination; and

(2) the benefits that would be payable from all other Plans without Coordination of Benefits provisions in those Plans;

would exceed such Allowable Expenses.

The benefits that would be payable from this **Plan** for Allowable Expenses **Incurred** in any Claim Determination Period in the absence of Coordination of Benefits will be reduced to the extent required so that the sum of:

(1) those reduced benefits; and

(2) all the benefits payable for those Allowable Expenses from all other Plans;

will not exceed the total of such Allowable Expenses.

Benefits payable from all other Plans include the benefits that would have been payable had proper claim been made for them. Only the amount paid by this **Plan** will be charged against the Maximum Benefit listed in the **Schedule of Benefits.**

However, the benefits of another Plan will be ignored when the benefits of this **Plan** are determined if: (a) the Benefit Determination Rules would require this **Plan** to determine its benefits before the other Plan**;** and (b) the other Plan has a provision that coordinates its benefits with those of this **Plan** and would, based on its rules, determine its benefits after this **Plan**.

Luminare Health reserves the right to release to or obtain from any other insurance company or other organization or person any information which, in its opinion, it needs for the purpose of Coordination of Benefits.

When payments, which should have been made under this **Plan** based on the terms of this section, have been made under any other Plans, Luminare Health will have the right to pay to any organizations making these payments the amount it determines to be warranted. Amounts paid in this manner will be released from all liability under this **Plan** to the extent of these payments. When an overpayment has been made by Luminare Health at any time, it will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other insurance company or organizations, as it may determine.

Automobile Limitation. When dental payments are available under vehicle insurance, this **Plan** will pay excess benefits only, without reimbursement for vehicle Plan deductibles. This **Plan** will always be considered the secondary carrier regardless of the **Participant's** election under personal injury protection with the auto insurance carrier.

Plan – for purposes of these Coordination of Benefits rules, means any of the following which provides medical or dental benefits or services: (a) group, blanket or franchise insurance coverage; (b) service plan contracts, group or individual practice or other prepayment plans; (c) coverage under any labor-management trustee plans; union welfare plans, employer organization plans; or employer or employee benefit organization plans; or (d) government programs or coverage required or provided by law. Plan does not include coverage under individual policies or contracts. Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Claim Determination Period – means a calendar year or that part of a calendar year in which the person has been covered under this **Plan**.

Allowable Expense – means any necessary, **Reasonable and Customary** item of expense at least a part of which is covered by any one of the Plans that covers the person for whom a claim is made. When the benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid. An Allowable Expense does not include any expense listed in the "Exclusions" section of this **Plan**. When this **Plan** is secondary, an Allowable Expense includes any **Deductible or Coinsurance** amounts not paid by the other Plan(s), but does not include any amount that is not payable under the primary Plan due to a contract between the primary Plan and a provider where the provider agrees to accept a reduced payment and to not balance bill the **Participant** for the difference.

Benefit Determination Rules

The rules below establish the order in which benefits will be determined under the **Plan's** Coordination of Benefits provisions:

(1) The following Plan will automatically be the primary Plan:

   a. A Plan that does not have a coordination of benefits provision; or

   b. A program or Plan that coordinates benefits according to different rules.

(2) This **Plan** is the primary Plan for all **Participants** covered by the **Plan** because they are **Employees** of a participating **Employer**. Similarly, any other Plan or program that covers an individual as an employee will pay benefits before a Plan covering the same person as a dependent.

(3) For **Dependent Children**, if both parents are enrolled in employer-sponsored Plans that cover their children as dependents:

a. The Plan of the parent whose birthday is earliest in the year will be the primary Plan;

b. If both parents have the same birthday (not taking the year into consideration), the Plan that has covered the child for the longest period of time will be the primary Plan, or

c. If the other parent's Plan coordinates its benefits according to the gender rule, the father's Plan will be primary.

(4) If the parents of a dependent child are divorced or separated:

a. If a Court decree places financial responsibility for dental care expenses on either parent, then that parent's Plan will be the primary Plan.

b. If a Court decree does not place financial responsibility for dental care expenses on either parent:

(i) the custodial parent's Plan will be the primary Plan; or

(ii) if the custodial parent has remarried, the custodial parent's Plan shall be the primary Plan, the stepparent's Plan shall be the secondary Plan; and then the non-custodial parent's Plan will determine its benefits, if any.

(5) The Plan covering a person as an active employee (or dependent of an active employee) will pay its benefits before the Plan that covers the person as a laid-off or retired employee (or dependent of a laid-off or retired employee).

(6) If none of the above rules determine the order of benefit payment, the Plan which has covered the individual for the longest period of time will be the primary Plan.

SUBROGATION AND REIMBURSEMENT

In certain circumstances, you or your **Dependents** (or your or your **Dependent's** heirs, executor, or beneficiaries) may have an obligation to reimburse the **Plan** for payments made to or on behalf of you or your **Dependents**. In particular, if you or your **Dependents** are entitled to any benefits under the **Plan** as a result of an injury or illness for which a third party is legally responsible or obligated to indemnify you (such as under a policy of insurance), then payments made by the **Plan** are only made on the condition that the **Plan** will be reimbursed by you or your **Dependents** to the extent of any amounts received from the third party. It does not matter whether the amounts received from the third party are as a result of a judgment rendered in a lawsuit, as a settlement of a claim, or otherwise. The obligation to repay the **Plan** for benefits paid in such a situation applies on a first dollar basis (i.e., has priority

over other rights) and is not subject to any offset or reduction because you or your **Dependents** had to pay legal fees or other expenses in securing the recovery from the third party or because you were not "made whole" by the recovery from the third party. In addition, the **Plan's** right to be repaid is enforceable regardless of the purpose of the payment by the third party or how it is characterized in any agreement or judgments between you or your **Dependents** and the third party.

By filing a claim for benefits, you or your **Dependents** consent to the right of reimbursement and agree to cooperate with the **Claims Processor** in any way necessary to enable the **Plan** to be reimbursed. Before any claims of this sort are paid, you or your **Dependents** must enter into a written subrogation and reimbursement agreement with the **Plan**, confirming the **Plan's** right to be reimbursed to the extent of any payments made or to be made under the **Plan**.

If you or your **Dependents** do not pursue recovery from the liable third party, the **Plan** is subrogated to the rights of you or your **Dependents** and may pursue the claim on your or your **Dependent's** behalf. In addition, you or your **Dependents** may not do anything that would prejudice the rights of the Plan to this right of reimbursement or subrogation, and payment of any claims to or on behalf of you or your Dependents may be delayed, withheld, or denied unless you or your **Dependents** cooperate fully and enter into the requested reimbursement and subrogation agreement.

PRETREATMENT REVIEW

What It Is. Pretreatment review is a system designed to assist you and your **Dentist** in understanding your dental coverage before the services are provided.

After Luminare Health has reviewed the proposed dental treatment and expected charges, you and your **Dentist** will be provided with a description of amounts payable for the particular covered services before the work is done.

How it Works. When charges for a proposed dental treatment plan for you or one of your **Dependents** are expected to be more than $300.00, your **Dentist** should submit to Luminare Health a claim showing the proposed services and fees. Luminare Health will then determine the benefits which will be payable for each dental service according to the terms of this **Plan**, including Alternate Treatment Limits and an explanation of benefits will be returned to the **Dentist**.

You and your **Dentist** can then discuss the proposed procedures and the benefits you will receive. When the treatment is completed, your **Dentist** will fill in the date each service was performed and resubmit the same form for payment.

If this Pretreatment Review process is not followed before the course of treatment begins, payment will be determined by Luminare Health taking into account alternate procedures or services for the dental condition. The maximum amount payable may

SUMMARY OF YOUR DENTAL PLAN BENEFITS

CLASS I PREVENTIVE & DIAGNOSTIC*
Oral Exams (initial or periodic) Twice in any consecutive 12-month period (unless otherwise limited in the Schedule of Benefits)
Teeth Cleaning (Routine or Periodontal Prophylaxis) Twice in any calendar year (unless otherwise limited in the Schedule of Benefits)
Fluoride Treatment Once in any consecutive 12-month period (unless otherwise limited in the **S**chedule of Benefits)
Emergency Pain Treatments
Space Maintainers (limited to ***Dependent Children*** as defined in the Schedule of Benefits) As needed to replace primary teeth
Sealants Coverage is limited to ***Dependent Children*** under the age of 14, once in any 36 consecutive month period.
Diagnostic X-rays Panorex **or** full-mouth series are covered once in any consecutive 36-month period (unless otherwise limited in the Schedule of Benefits)
Tests & Lab Exams

The deductible does not apply to Class I benefits.
Payment for Class I services applies to the Plan Year maximum listed in the Schedule of Benefits.

The above is a general summary only. See the **Schedule of Benefits for information regarding **Deductibles**, payment percentages and maximums that apply to your group. **The Schedule of Benefits at the front of this booklet overrides any provisions listed above.***

SUMMARY OF YOUR DENTAL PLAN BENEFITS

CLASS II BASIC RESTORATIVE*
Fillings Amalgams, Silicate, Acrylic
Root Canal Therapy (Endodontics)
Repair of Bridgework & Dentures (only if done more than six months after the initial insertion)
Extractions and Oral Surgery
General or Local Anesthesia when Medically Necessary for Oral Surgery
Removal of Impacted Teeth
Treatment of Gum Disease (Periodontics)
Rebasing and Relining of Present Dentures (as limited in the Schedule of Benefits)

The deductible applies to Class II benefits.
Payment for Class II services applies to the Plan Year maximum listed in the Schedule of Benefits.

The above is a general summary only. See the **Schedule of Benefits for information regarding **Deductibles**, payment percentages and maximums that apply to your group. **The Schedule of Benefits at the front of this booklet overrides any provisions listed above.***

SUMMARY OF YOUR DENTAL PLAN BENEFITS

CLASS III MAJOR RESTORATIVE*
Inlays, Onlays, Gold Fillings, or Crown Restorations Once in any 5 consecutive year period per tooth
Installation of Fixed Bridgework Once in any 5 consecutive year period per tooth
Installation of Partial or Complete Dentures Once in any 5 consecutive year period per tooth
Replacement of Existing Bridgework or Dentures Once in any 5 consecutive year period per tooth

The deductible applies to Class III benefits.
Payment for Class III services applies to the Plan Year maximum listed in the Schedule of Benefits.

The above is a general summary only. See the **Schedule of Benefits for information regarding **Deductibles**, payment percentages and maximums that apply to your group. **The Schedule of Benefits at the front of this booklet overrides any provisions listed above.***

SUMMARY OF YOUR DENTAL PLAN BENEFITS

CLASS IV ORTHODONTIA*
Full-Banded Orthodontia Treatment
Appliances for Tooth Guidance
Appliances to Control Harmful Habits
Retention Appliance

The deductible does not apply to Class IV benefits.
Payment for Class IV services applies to the lifetime orthodontia maximum listed in the Schedule of Benefits.

The above is a general summary only. See the **Schedule of Benefits for information regarding **Deductibles,** payment percentages and maximums that apply to your group. **The Schedule of Benefits at the front of this booklet overrides any provisions listed above.***

be based on the charge for a dental service which provides professionally adequate treatment at a lesser charge. This determination will be based upon acceptable standards of dental practice.

Pretreatment Review is not required, but is recommended for courses of treatment over $300.00.

Pretreatment Review does not guarantee payment. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed.

EXPENSES NOT COVERED

In addition to the general exclusions listed later in this Summary, no payment will be made by the **Plan** for:

1. Services performed solely for cosmetic reasons, including charges for personalization or characterization of dentures;

2. Replacement of a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability;

3. Treatment by other than a **Dentist**, except that scaling or cleaning of teeth and topical application of fluoride will be considered a **Covered Expense** if performed by a licensed dental hygienist under the supervision and guidance of the **Dentist**;

4. Services or supplies which are unnecessary or **Experimental** according to accepted standards of dental practice;

5. Replacement of a lost, missing or stolen prosthetic device;

6. Spare or duplicate prosthetic devices or appliances;

7. Charges for sealants (except for **Dependent Children** under the age of 14), for oral hygiene and dietary instruction, for implantology, and for a plaque control program;

8. Appliances or restorations, other than full dentures, whose primary purpose is to increase vertical dimension or stabilize periodontally involved teeth (splinting), or to restore the occlusion;

9. Services or supplies which are furnished prior to the effective date of coverage, including a service which is: (a) an appliance, or modification of an appliance, for which an impression was made before you became covered under the **Plan**,

(b) a crown, bridge or gold restoration, for which a tooth was prepared before you became covered under the **Plan**, or (c) root canal therapy, for which the pulp chamber was opened before you became covered under the **Plan**;

10. Replacement of a bridge or denture within five years following the date of its installation unless (a) such replacement is made necessary by the placement of an original opposing full denture or the extraction of natural teeth; or (b) the bridge or denture, while being worn, has been damaged beyond repair as a result of an accidental injury;

11. Expenses to the extent they are not payable according to the section of this Summary entitled General Limitations;

12. Diagnosis or treating conditions or dysfunction of the temporomandibular joint;

13. Porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second and third molars;

14. Bite registrations;

15. Precision attachments;

16. Services that are deemed to be medical services;

17. All services, supplies and treatment related to dental implants, except charges for a prosthesis attached to an implant;

18. Any procedure not listed under the Summary of Your Dental Plan Benefits Section of this Summary or the Section titled Covered Dental Expenses in the **Plan** document;

19. Charges for over-dentures, including related root canal therapy and supportive restorations;

20. Charges in excess of the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition;

21. Charges resulting from changing from one **Dentist** to another while receiving treatment, or from receiving care from more than one **Dentist** for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one **Dentist** had performed all the required services.

GENERAL EXCLUSIONS
NO BENEFITS WILL BE PAID FOR EXPENSES INCURRED:

1. For services for which expenses are covered or obtained through any workers' compensation or similar law, by stipulation or otherwise;

2. For charges which you or your **Dependents** are not legally required to pay;

3. For charges which would not have been made had coverage not existed;

4. For charges by a hospital owned or operated by the United States Government, except in a foreign country, or for the treatment of a non-service connected illness or disability in Veteran's Administration hospitals or for **Covered Expenses**, for care while confined in a military medical facility, which are **Incurred** by a U. S. military retiree and his or her covered **Dependents**, if any;

5. In excess of the **Reasonable and Customary** amount for the locality in which they are **Incurred**;

6. To the extent that payment under this **Plan** is prohibited by any law to which you or your **Dependents** are subject at the time expenses are **Incurred**;

7. To the extent that charges are otherwise payable as described under the Coordination of Benefits provisions;

8. Charges for completion of any claim forms, or charges for failure to keep appointments;

9. For charges for unnecessary care, treatment or surgery;

10. No payment will be made for expenses **Incurred** by you or any one of your **Dependents** to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law;

11. For charges deemed to be medical services.

Luminare Health will take into account any adjustment option chosen under such part by you or any one of your **Dependents**.

CANCELLATION

Employee Coverage. Your coverage will be canceled at the earliest time specified below:

1. on the day your **Employer** terminates participation in the **Plan** and offers no other group dental plan;

2. on the day of your termination of employment;

3. on the day you cease to be an eligible **Employee**; or

4. on the day you stop making any required contributions.

Dependent Coverage. Coverage for your **Dependent(s)** will cease at the earliest time specified below:

1. on the day your coverage terminates;

2. on the day the individual ceases to qualify as a **Dependent** as defined;

3. the date the **Employer** or the **Plan** discontinues **Dependent** coverage for any and all **Dependents;** or

4. the date you stop making any required contributions on the **Dependent's** behalf.

If an unmarried **Dependent Child** ceases to be eligible as a **Dependent**, he or she may again become an eligible **Dependent** in certain circumstances. Consult the Plan document or contact Luminare Health for more details.

Dental Benefits Extension. An expense **Incurred** in connection with a **Covered Expense** that is completed after a person's benefits cease will be deemed to be **Incurred** while covered if:

For fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while covered and the device installed or delivered within 3 calendar months after coverage ceases;

For a crown, inlay or onlay, the tooth is prepared while covered and the crown, inlay or onlay installed with 3 calendar months after coverage ceases; or

For root canal therapy, the pulp chamber of the tooth is opened while covered and the treatment is completed within 3 calendar months after coverage ceases.

There is no extension for any **Covered Expense** not shown above.

COBRA CONTINUATION COVERAGE

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA Continuation Coverage is a temporary extension of coverage, available to you and to other members of your **Family** who are covered under the **Plan**, at group rates in certain instances where coverage under the **Plan** would otherwise end. **This information is intended to provide notice and explain, in a summary fashion, COBRA Continuation Coverage, when it may become available to you and your Family, and what you must do to continue your coverage under the Plan, including what to do to protect the right to receive it.** This information gives you only a summary of your COBRA Continuation Coverage rights. Both you and your spouse, if any, should take the time to read this information carefully. For more information about your rights and obligations under the **Plan** and under federal law, you should contact your **Employer** or the **Claims Processor**.

COBRA Continuation Coverage is a continuation of **Plan** coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. 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.

Qualifying Events.

If you are a **Participant** covered by the **Plan**, you will become a qualified beneficiary if you lose your group coverage under the **Plan** because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of the **Participant**, you will become a qualified beneficiary if you lose group coverage under the **Plan** for any of the following reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than his or her gross misconduct) or reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes enrolled in Medicare (Part A, Part B or both).

In the case of a **Dependent Child** of the **Participant**, he or she will become a qualified beneficiary if the Child's coverage under the Plan is lost for any of the following reasons:

1. The death of the **Participant**;
2. The termination of the **Participant's** employment (for reasons other than the **Participant's** gross misconduct) or reduction in the **Participant's** hours of employment with the **Employer**;
3. Parents' divorce or legal separation;
4. A parent becomes enrolled in Medicare (Part A, Part B or both); or
5. The Dependent ceases to be a **"Dependent Child"** eligible for coverage under the **Plan**.

If there is a choice among types of coverage under the **Plan**, each person eligible for COBRA Continuation Coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or **Dependent Child** is entitled to elect COBRA Continuation Coverage even if the **Participant** does not make that election.

The **Plan** will offer COBRA Continuation Coverage to qualified beneficiaries only after the **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**, commencement of a proceeding in bankruptcy with respect to the **Employer** or enrollment of the **Employee** in Medicare (Part A, Part B or both), the **Employer** must notify the **Administrator** of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of you and your spouse, or a Dependent Child's loss of eligibility for coverage as a Dependent Child), you must notify the Administrator. The Plan requires you to notify the Administrator within 60 days after the qualifying event occurs. You must send this notice to your Employer. Your notice must be in writing and must include: (1) the Plan name, (2) the name of the Participant and each qualified beneficiary impacted by the qualifying event, (3) the type of qualifying event and (4) the date of the qualifying event. The notice to the Plan can be provided by the Participant, the qualified beneficiary or any representative on behalf of the Participant or the qualified beneficiary.

Once the **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.

Maximum Length of Coverage.

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is the death of the **Employee**, enrollment of the **Employee** in Medicare (Part A, Part B or both), 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 employment or reduction of the **Employee's** 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.

1. **Disability Extension of 18-Month Period of Continuation Coverage - If you or anyone in your Family who is 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 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. You must make sure that the Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA Continuation Coverage. This notice should be sent to your Employer. The notice must be in writing and must include: (1) the Plan name, (2) the name of the Participant and the disabled qualified beneficiary, if different, (3) the date of the Social Security's determination of disability and (4) a copy of the Social Security's determination of disability. The notice can be provided by the Participant, the qualified beneficiary or any representative on behalf of the Participant or the qualified beneficiary.**

2. **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 get 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, enroll in Medicare (Part A, Part B or both), or 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 Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to your Employer. The notice must be in writing and must include: (1) the Plan's name, (2) the name of the Participant and each qualified beneficiary impacted by the second qualifying event, (3) the nature of the second qualifying event and (4) the date of the second qualifying event. The notice can be provided by the Participant, the qualified beneficiary or any representative on behalf of the Participant or the qualified beneficiary.**

If you have questions about your COBRA Continuation Coverage, you should contact your **Employer** or the **Claims Processor** 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.**

In order to protect your Family's rights, you should keep the 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 **Administrator.**

USERRA CONTINUATION COVERAGE

If you or your **Dependent** is called for active duty by the United States Armed Services (including the Coast Guard), the National Guard or the Public Health Service, you or your **Dependent** may continue dental coverage, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than 31 days, you or your **Dependent** can not be required to pay more than the **Employee's** share, if any, applicable to your dental coverage. If the leave is more than 31 days, then the **Employer** may require you or your **Dependent** to pay no more than 102% of the full contribution amount.

The maximum length of the continuation coverage required under USERRA is the lesser of:

(1) Twenty-four months beginning on the day that the leave commences, or

(2) A period beginning on the day that the leave began and ending on the day after the **Employee** fails to return to employment within the time allowed.

If a second Qualifying Event occurs during the 24-month period of USERRA coverage, another election to extend coverage for up to an additional 12 months may be available. Your or your **Dependent's** coverage will be reinstated without exclusions or a waiting period upon the conclusion of the USERRA leave if you return to employment per USERRA's requirements.

FAMILY SECURITY BENEFIT

Provided your **Employer** has elected this benefit as listed in the **Schedule of Benefits**, in the event of your death, dental coverage will be continued for your **Family** members covered on that date, without payment of premiums, until the earliest of the following dates:

(1) remarriage of your surviving spouse, in which case the coverage for all **Family** members terminates;

(2) the date a **Family** member ceases to qualify as a **Family** member for any reason other than lack of primary support by you;

(3) two years from the date of your death; or

(4) the date the **Employer** terminates participation in the **Plan**.

The coverage which is continued for **Family** members will be the coverage in force at the time of your death.

The coverage which is continued in force for **Dependent Children** because of your death will not be affected if your surviving spouse dies during the two year (maximum) continuation of coverage period after your death.

GENERAL PROVISIONS

Time of Payment of Benefits.

Before a claim for payment can be considered, you must submit a properly completed claim form. All benefits will be paid immediately upon receipt of proof of loss. See the Section of this Summary titled "How to File a Claim" for additional information.

Notice and Proof of Loss.

A claim form must be completed and signed by both you and your **Dentist**, and furnished to the **Claims Processor** within 90 days after the date of the dental services for which the claim is made.

Additionally, X-rays or dental records must be promptly furnished to the **Claims Processor** upon request.

The claim form and all supporting evidence is considered Proof of Loss to the **Plan**.

Failure to furnish Proof of Loss within the time specified will neither invalidate nor reduce any claim if it can be shown that it was not reasonably possible to furnish Proof of Loss within that time, and that such Proof was furnished as soon as was reasonably possible.

Facility of Payment of Benefits.

If an **Employee** is a minor or, in the opinion of the **Claims Processor**, is incapable of giving a valid receipt for payment of any benefits due him under the **Plan**, and if no request for payment has been received by the **Claims Processor**, the

Claims Processor, may at its option, make payment to the individual or institution appearing to have assumed the custody or principal support of the **Employee**. Dental benefits will be paid, at the option of the **Employee**, to the **Employee** or directly to the **Dentist** on whose charges the claim is based.

Any payment made in accordance with this Facility of Payment provision will discharge the **Claims Processor** and the **Employer** from all further liability to the extent of the payment made.

Legal Actions.

Agent for Service of Legal Process - the **Plan** is a legal entity. Legal notices may be filed with, and legal process served upon, either the **Claims Processor** or the **Administrator,** as identified in this Summary.

Amendment and Termination.

The **Employer** and the **Administrator** have the right to amend the **Plan** at any time provided the amendment does not eliminate benefits to which you have already become entitled. While the **Administrator** expects the **Plan** to be continued, future conditions affecting the **Employer** or the **Administrator** cannot be anticipated. Therefore, the **Administrator** has reserved the right to terminate the **Plan**.

No Enlargement of Employment Rights.

Nothing contained in the **Plan** is to be construed as a contract of employment between the **Employer** and you, nor shall the **Plan** be deemed to give you the right to be retained in the employ of the **Employer**, or to limit the right of the **Employer** to employ or discharge you or to discipline you, for any reason or for no reason.

HOW TO FILE A CLAIM

Filing a claim under the **Plan** is a simple procedure.

When you or a **Dependent** see a **Dentist**, all you have to do is fill out the personal information requested on the top of the claim form. Be sure that all information requested is given and sign the form.

Your **Dentist** will then complete the rest of the form. Once the form has been completed and signed, you or the **Dentist** will send it to the **Claims Processor**, at the address preprinted at the top of the form.

If the proposed course of treatment is expected to cost more than $300.00, your claim will go through pretreatment review. (See the section of this Summary titled "Pretreatment Review".) In this event, your **Dentist** will complete the claim form

detailing the treatment and send it to the claim office before beginning the work. There the plan of treatment will be reviewed and the benefits payable will be determined and the form returned to your **Dentist**. He or she can discuss the review with you so you both know before treatment begins just what will be paid under the **Plan.**

Benefits may be paid to you or directly to your **Dentist**. If payment is to be made to your **Dentist**, be sure to sign the "assignment of benefits" clause directly below your first signature. Regardless of who receives the payment, you will receive a payment voucher showing the amount paid and how it was calculated under the **Plan**.

You may pick up claim forms from your **Employer**. If your **Employer** does not have a supply of the forms, you may obtain additional forms by writing to the **Claims Processor**. All claims must be submitted to the **Claims Processor** within 6 months of the date the claim was **Incurred**.

Foreign Claims.

Benefits for dental expenses **Incurred** in a foreign country will be paid only if the care was for an emergency. If you **Incur** a **Covered Expense** in a foreign country, you are responsible for providing the following information to the **Claims Processor** before payment of any benefits:

(1) The claim form, provider invoice and any other documentation required to process the claim – all forms must be translated to English.

(2) The charges for services as converted to dollars.

(3) A current conversion chart validating the conversion from the foreign country's currency to dollars.

Claims Notification.

If your claim for dental benefits is wholly or partially denied, the **Claims Processor** will notify you of its decision in a writing which will contain: (a) specific reasons for the claim's denial, (b) specific reference to pertinent **Plan** provisions, (c) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary, and (d) information as to the steps to be taken if you wish to submit a request for review. In addition to the information above, the notice will also contain any information regarding an internal rule, guideline or protocol that was relied on in making the benefit determination and, if the denial is based on **Medical Necessity**, **Experimental** treatment or a similar exclusion or limit, an explanation of the scientific or clinical judgment used in the determination. If the notice does not contain such statements or explanations, the notice will contain a statement

indicating that this information will be provided upon written request at no charge. This notification will be given within the following timeframes, depending on the type of claim:

Pre-Service claims – within a reasonable time, but no later than 15 days after receipt of your claim. The review period may be extended for 15 days due to matters beyond the **Claims Processor's** control if the **Claims Processor** notifies you of the extension before the end of the first 15-day period, the circumstances requiring the extension and the date by which the **Claims Processor** expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information and the time period for deciding your claim will be suspended until the earlier of (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information. Also, please see the above Section regarding Pretreatment Reviews.

Post-Service claims – within a reasonable time, but no later than 30 days after receipt of your claim. The review period may be extended for 15 days due to matters beyond the **Claims Processor's** control if the **Claims Processor** notifies you of the extension before the end of the first 30-day period, the circumstances requiring the extension and the date by which the **Claims Processor** expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information and the time period for deciding your claim will be suspended until the earlier of (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information.

If notice of a benefits determination is not given to you within the applicable time period, your claim will be considered denied as of the last day of the applicable review period.

Appeals.

If your claim is denied and you wish to have the claim reconsidered, you, or your authorized representative on your behalf, may appeal and request a review of your claim. Your appeal must be received by the **Claims Processor** within 180 days. You may submit additional comments, records and documents related to your claim. You may also, upon request and at no charge, review copies of the documents and information relevant to your claim.

Appeal Notification.

If your appeal is received by the appropriate deadline, the **Claims Processor** will independently review your appeal and any additional information that you submit. The **Claims Processor** will notify you of its decision regarding your appeal within the following timeframes:

Pre-Service claims – within a reasonable period, but no later than 30 days after receipt of your appeal.

Post-Service claims – within a reasonable period, but no later than 60 days after receipt of your appeal.

If your appeal is denied, the **Claims Processor** will send you a statement containing: (a) specific reasons for the denial, (b) specific references to pertinent **Plan** provisions, (c) a statement that you may have access to or receive, upon request and at no charge, copies of all documents, records and information relevant to your claim and (d) a statement describing any voluntary appeal procedures offered by the **Plan**. In addition to the information above, the notice will contain any information regarding an internal rule, guideline or protocol used in making the appeal decision and an explanation of the scientific or clinical judgment used in the denial. If the appeal notice does not contain such statements or information, the notice will contain a statement indicating that this information is available upon written request and at no charge.

If notice of a benefits determination is not given to you within the applicable time period, your claim will be considered denied as of the last day of the applicable review period.

In order to make full use of the benefits available under this **Plan**, you should become fully aware of the provisions of the **Plan** and the benefits it provides. The coverage available to you is described in this Summary booklet. Please read it carefully. If you have any questions, please call us - toll free. We're here to help you.

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