



**PESC
Administrators**

For Employees of:

XYZ Corporation

Group Number 99999

Group Dental Program Summary Plan Description

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded welfare plan and the administration is provided through a third-party Claims Processor.

PLAN NAME

XYZ CORPORATION Self-Funded Dental Benefit Plan

GROUP NUMBER: 00000 XYZ CORPORATION

PLAN EFFECTIVE DATE: August 1, 2002

PLAN YEAR: June 1—May 31

EMPLOYER INFORMATION

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(559) 291-4444

PLAN ADMINISTRATOR

XYZ CORPORATION

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XYZ CORPORATION

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CLAIMS PROCESSOR

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DENTAL PPO NETWORK

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INTRODUCTION

This document is a description of XYZ CORPORATION Group B and C Dental Benefit Plan (the Plan). Coverage under the Plan will take effect for an Employee only if the Employee is eligible for coverage and becomes and remains covered by the terms of the Plan.

The benefits described in this document are self-funded by the Employer. Funds for the payment of these benefits including payroll-deducted contributions by Employees are paid into a fund by the Employer.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the Plan at any time upon advance notice to all Participants.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility and the like.

If the Plan is terminated, the rights of Covered Persons are limited to Covered Expenses incurred before termination.

In this document, we have avoided the use of specific gender pronouns whenever possible. However, where such avoidance would have led to very awkward sentences, we have used the masculine pronoun. This use should be considered to refer to both genders.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who performs all of the duties of his job with the Covered Employer on a full-time basis. This job may be at either Covered Employee's normal place of employment or at some other place to which the regular business operations of the Covered Employer require that person to go.

To be "full-time", an Active Employee must be scheduled to work for the Covered Employer at least 30 hours per week and on the regular payroll of the Covered Employer for that work.

Active Work is work performed as an Active Employee. "Actively At Work" means being engaged at Active Work.

ADA Code means the American Dental Association Code assigned to a particular dental procedure.

Calendar Year means January 1st through December 31st of the same year.

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

Covered Dental Expense (Covered Expenses) is the expense incurred for a covered service or supply, but not more than the maximum amounts described in 1 and 2 below. Expense is incurred on the date service or supply is received. Covered Dental Expense does not include:

1. For all Participating Dentists, any charge in excess of the Dental Negotiated Rate; or
2. For Non-Participating Dentists any charge in excess of the 90th percentile of the NDAS Fee Schedule.

Covered Employer is the following named Employer: XYZ CORPORATION.

Covered Person is an Employee or Dependent who is covered under this Plan.

Dental Negotiated Rate is the amount Participating Dentists agree to accept as payment in full for covered services. It is usually lower than their normal charge. Dental Negotiated Rates are determined by the Participating Provider Agreements.

Dentist is a person who is licensed to practice by the governmental authority having jurisdiction over the licensing and practice of dentistry.

Dependent is any one of the following persons:

1. An Employee's spouse is defined as a spouse under a legally valid marriage between persons of the opposite sex. Spouse does not include any person who is a covered Employee or in the active service of the Armed Forces.
2. Unmarried children from birth to 19 years of age. However, a Dependent child will continue to be covered from age 19 provided the child is a full-time student at an accredited school, primarily dependent upon his parents for support and maintenance, unmarried and under age 24.
3. A covered Dependent child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, chiefly dependent upon his parents for support and maintenance, unmarried and was covered under the Plan when reaching the limiting age. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Employee's expense, to determine the existence of such incapacity.

4. A child who is in the process of being adopted is considered a legally adopted child if legal evidence of both the intent to adopt and that the Employee or spouse have either the right to control the health care of the child or assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.

Legal evidence to control the health care of the child means a written document including, but not limited to, a health facility minor release report, a medical authorization form or relinquishment form signed by the child's birth parent or other appropriate authority; or, in the absence of a written document, other evidence of the Employee's or spouse's right to control the health care of the child.

5. The term "child" does not include any child for whom the Employee or spouse is the legal guardian and who is not the Employee's or spouse's natural child, stepchild or adopted child.

These persons are excluded as Dependents:

1. The legally separated or divorced former spouse of the Employee;
2. Any person who is on active duty in any military service of any country.

Employee is an Employee of a Covered Employer who is eligible for coverage under the Plan.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental care and treatment is that which is not approved or accepted as essential to the treatment of Injury or Sickness by The American Medical Association, The United States Surgeon General, The United States Department of Public Health, The National Institute of Health, The American Dental Association or The American Osteopathic Association.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the Covered Employee and his family members who are covered as Dependents under the Plan.

Health Care Provider is a licensed or certified provider other than a Physician whose services are given within the scope of that provider's license or certification.

HIPAA is The Health Insurance Portability and Accountability Act of 1996.

Injury is an accidental bodily Injury.

Late Enrollee. An applicant for personal or Dependent coverage who declined coverage when first eligible in the Plan and later chooses to enroll in the Plan. Such Late Enrollee will be subject to special Late Enrollee rules of the Plan.

Negotiated Charges means those charges and fees agreed upon between Network Providers and Central Valley Dental Partners.

Network Provider or Preferred Provider means a Dentist, Physician, or providers of dental care services or supplies who has entered into a contractual relationship with Central Valley Dental Partners, and whose fees, charges, etc. are governed by the terms and conditions of each contract. A list of Preferred Providers will be furnished to the holder or each member.

Non-Participating Dentist is a Dentist who does NOT have a Participating Provider Agreement with the contracted PPO(s).

Open Enrollment. One Open Enrollment period will be allowed each year at times designated by XYZ CORPORATION. During the Open Enrollment period, you may elect dental coverage without being subject to the late enrollment penalty.

Participating Dentist is a Dentist who has a Participating Provider Agreement in effect with a contracted PPO at the time services are rendered. Participating Providers agree to accept the Dental Negotiated Rate as payment for covered services. A directory of Participating Dentists is available from the Plan Administrator upon request.

Plan Year means June 1st through May 31st of the next year.

Prescription Drug means any of the following:

1. A drug or medicine that, under federal law, is required to bear the legend, "Caution: Federal law prohibits dispensing without prescription."
2. Compounded medicines of which at least one ingredient is included under item (1) above.

Total Disability (Totally Disabled) means, in the case of an Active Employee, the complete inability to perform because of Injury or Sickness any and every duty of the Employee's occupation or employment.

In the case of a Dependent or Retired Employee, it means the complete inability to perform the normal activities of a person of like age and sex in good health.

Usual, Customary and Reasonable Charge is a charge which is determined to fall within the common range of fees billed by a majority of Dentists for a procedure in a given geographic region. If it exceeds that range, the expense must be justified based on the complexity or severity of treatment for a specific case.

TYPES OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

PARTICIPATING DENTISTS

The Plan has contracted with a network of various types of "Participating Dentists". These Dentists are called "participating" because they have agreed to participate in a Preferred Dentist Organization Network (PPO) called Central Valley Dental Partners. They have agreed to provide Covered Persons with dental care at a negotiated fee.

A directory of Participating Dentists is available from your Plan Administrator (Employer).

NON-PARTICIPATING DENTISTS

Non-Participating Dentists are Dentists who have not agreed to participate in the PPO network. They have not agreed to the Dental Negotiated Rates and other provisions contained in the PPO contract. It will be the patient's responsibility to pay for all fees, which exceed the Usual, Customary, and Reasonable fees.

HOW TO SUBMIT A CLAIM

Just have your Dentist submit claims on any form approved by the Council on Dental Care Programs or AMERICAN DENTAL ASSOCIATION.

WHEN CLAIMS MUST BE FILED

Claims must be filed with the Claims Processor within 30 days of the date charges for the service were incurred. Claims filed later than that date may be declined or reduced unless:

1. It's not reasonably possible to submit the claim in that time; and
2. The claim is submitted within one year from the date incurred. This one-year period will not apply when the person is not legally capable of submitting the claim.

The Claims Processor will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

GENERAL CLAIMS INFORMATION

Benefits may be reduced if you or your Dependent has benefits under another Plan. Since the use of Network Providers does not require you to complete a claim form, the Plan Administrator reserves the right to request other dental insurance coverage information, as frequent as but not greater than, once every 3 calendar months.

Claims for Dependents enrolled in college. When you submit a claim for a Dependent enrolled in an Educational Institution, you must submit proof of enrollment. For the purposes of this Plan, Educational Institution shall mean an institution accredited in the current publication of Accredited Institutions of Higher Education, including vocational technical schools. This includes a paid tuition receipt or letter from the registrar. Proof of enrollment must be submitted every six months.

The Plan pays benefits directly to any Network dental Provider who makes charges to you for covered services.

The Plan pays benefits directly to you for other dental Providers who make charges to you for covered services. You can request in writing that these payments be made directly to these dental providers. You do this when you fill out a claim form.

If the Plan pays dental benefits for expenses incurred on account of you or your Dependent, you or any other person or organization that was paid must make a refund to the Plan if;

1. All or some of the expenses were not paid by you or your Dependent or did not legally have to be paid.
2. All or some of the payment made by the Plan exceeded the benefits under the Plan.
3. All or some of the expenses were recovered from or paid by a source other than this Plan. This may include payments made as a result of claims against a third party for negligence, wrongful acts or omissions.

The refund equals the amount the Plan paid in excess of the amount it should have paid under the Plan. In the case of recovery from or payment by a source other than this Plan, the refund equals the amount of the recovery or payment up to the amount the Plan paid.

If the refund is due from another person or organization, you and your Dependent agree to help the Plan get the refund when requested.

If you, or any other person or organization that was paid, do not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under the Plan. The Plan may also reduce future benefits under any other group benefits plan administered for the Employer. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

CLAIMS REVIEW PROCEDURE

In cases where a claim for benefits payment is denied in whole or in part, the claimant may appeal the denial. This appeal provision will allow the claimant to:

1. Request from the Plan Administrator a review of the eligibility status for any claim denied in whole or in part.
2. Request from the provider of benefits a review of any claim payment. Such request must include: the name of the Employee, his Social Security No., the name of the patient and the Group Identification Number, if any.
3. File the request for review in writing, stating in clear and concise terms the reason or reasons for disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Claims Processor within 60 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator, and the Plan Administrator will provide the claimant with a written response within 60 days of the date the Plan Administrator receives the claimant's written request for review. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the claimant of the delay within the 60-day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the claimant's written request for review.

The Plan Administrator's written response to the claimant shall, if denial is upheld, cite the specific Plan provision(s) upon which the denial is based.

SUMMARY OF BENEFITS

DENTAL CHARGE BENEFITS

IN-NETWORK BENEFITS

Annual Deductible (applies to Basic and Major Services only), per person.....	\$25.00
Class I Benefits - Diagnostic and Preventive	100%
Class II Benefits – Basic	80%
Class III Benefits - Major	65%
Orthodontia	65%

Maximum Benefit Amount:

Per person per Plan Year	\$1,200.00
(Class I, II, III)	
Orthodontia (Lifetime Maximum).....	\$800.00

OUT-OF-NETWORK BENEFITS

Annual Deductible (applies to Basic and Major Services Only), per person.....	\$50.00
Class I Benefits - Diagnostic and Preventive	100%*
Class II Benefits – Basic	70%*
Class III Benefits - Major	50%*
Orthodontia	50%*

Maximum Benefit Amount:

Per person per Plan Year	\$1,000.00
(Class I, II, III)	
Orthodontia (Lifetime Maximum)	\$800.00

* Allowable fees are based on the 90th percentile of the National Dental Advisory Survey (NDAS). Patients who visit non-PPO providers will be responsible for amounts that exceed the 90th percentile of the NDAS fee schedule plus applicable copayments.

HOW COVERED DENTAL EXPENSE IS DETERMINED

If a CVDP PPO contracted provider is seen, the Plan will pay 100% of covered fees for covered diagnostic and preventive benefits, 80% of covered fees for the covered basic benefits, and 65% of the covered fees for the covered major benefits. If a non-CVDP PPO or Out-of-Network Provider is seen, the Plan will pay 100% of covered fees for covered diagnostic and preventive benefits, 70% of covered fees for the covered basic benefits, and 50% of the covered fees for the covered major benefits. Covered Dental Expense is based on a maximum charge for each covered service (the NDAS fee schedule) or supply which the Plan will accept. It is **not** necessarily the amount a Dentist bills for the service.

Covered Dental Expense will always be the lesser of the billed charge or the amount shown below:

Participating Dentist – The Dental Negotiated Rate

Participating Dentists have agreed not to charge more than the Dental Negotiated Rate. When a Participating Dentist is chosen the Covered Person will not be responsible for any amount in excess of the Dental Negotiated Rate for the services of a Participating Dentist.

Non-Participating Dentist – (90th percentile of the National Dental Advisory Survey (NDAS) fee schedule). Non-Participating Dentists are Dentists who have not agreed to participate in the PPO network. They have not agreed to the Dental Negotiated Rates and other provisions contained in the PPO contract.

The Covered Person will be responsible for any billed charge which exceeds the Dental Negotiated Rate or NDAS fees for services provided by a Non-Participating Dentist.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

EMPLOYEE COVERAGE

Eligible Classes of Employees

All Active Full-Time Employees of a Covered Employer.

Eligibility Requirement for Employee Coverage

1. Is an Employee of the Covered Employer; and
2. Employee is in a class eligible for coverage.

WARNING: No Employee may decline coverage or fail to enroll himself unless he completes and signs the "Refusal/Waiver Form" Notice provided by the Employer or Plan Administrator.

If a person works for two or more Covered Employers under the Plan, there will be no multiple coverage. The person will be eligible as the Employee of the Covered Employer determined by the Plan Administrator. Also, the total hours worked by the person for all Covered Employers will be used for determining full-time employment status.

No corporate officer or director will be eligible solely due to the person's title. The person must be an Active Employee to be eligible.

Each eligible Employee may elect Employee coverage by signing an enrollment form approved by the Plan Administrator. The effective date of his coverage depends on the date on which the Employee elects coverage.

1. If elected on, or before, or within 30 days after he becomes eligible, his coverage will become effective on the first day of the month coinciding with or next following the completion of the waiting period.
2. If coverage is applied for more than 30 days after the Employee becomes eligible, then the Employee is defined as a **"Late Entrant"** and is subject to the **Late Entrant Limitation** as outlined in the section titled **DENTAL BENEFITS**.
3. A **Late Entrant** does not include an Employee who waives Plan coverage, by completing a "Refusal/Waiver Form" when first eligible, due to other Employer-sponsored coverage (such as coverage through a spouse, parent or other employment), and later applies for coverage under the Plan within 30 days of such other coverage termination by submitting a new enrollment form along with proof of prior coverage acceptable to the Plan Administrator, then the **Late Entrant Limitation** requirement will not apply and Plan coverage will commence immediately upon termination of such prior coverage. However, if Plan coverage was waived for reasons other than other coverage (such as unwillingness to pay the required share of the cost of coverage), an individual may apply for Plan coverage but it will be deferred as outlined in the **Late Entrant Limitation**.

Rehiring a Terminated Employee. A terminated Employee who is rehired must satisfy the Eligibility Requirement again. However, an Employee returning to work directly from coverage under the Plan's COBRA continuation option need not satisfy the employment waiting period.

Active Work Requirement

Active Employees - An Employee must be at Active Work for a benefit or a benefit increase to take effect. The benefit or increase will be deferred if, on the date that it is due to take effect, the Employee is not at Active Work. In this Case, the new coverage will not take effect until the first day that the Active Employee is at Active Work and meets all other requirements needed to effect the coverage.

The Employee will be considered at Active Work on a regularly scheduled non-working day if the Employee is not then disabled and could have been engaged in Active Work had it been a work day and was engaged in Active Work on the last preceding regular work day.

Effective Date of Employee Coverage. An Employee will be covered for a new benefit or a benefit increase as of the first day of the calendar month following the date that the Employee satisfies all of the following:

1. The Eligibility Requirement.
2. The Active Work Requirement.
3. The Enrollment Requirement.

A decrease in the level of an Employee's benefits due to a change in class or earnings will take effect as of the date of that change.

When Employee Coverage Terminates. Employee Coverage will terminate on the earliest of these dates:

1. The date the Plan is terminated.
2. The date the person's Employer ceases to be a Covered Employer.
3. The last day of the month a Covered Person ceases to be in one of the Eligible Classes (See the COBRA Continuation Option).
4. The date the person enters active duty with the Armed Forces of any country or international authority.

Any time you are not on active service, you are considered to have ceased employment except in these instances:

1. If you are temporarily laid-off, coverage may continue for up to 60 days; or
2. If you are on an approved disability leave of absence, coverage may continue for up to 6 months; provided required contributions continue to be made and the coverage is not otherwise canceled. Any continuation of coverage must be in accordance with a Plan that prevents individual selection.

DEPENDENT COVERAGE

Eligibility Requirement for Dependent Coverage

An Employee becomes eligible for Dependent Coverage on the first day that the Employee is eligible for Employee Coverage and has a Dependent.

WARNING: No Employee may decline coverage for, or fail to enroll, eligible Dependents unless he completes and signs the "Refusal/Waiver Form" Notice provided by the Employer or Plan Administrator.

Requirements for Effecting Dependent Coverage

1. Enrollment Requirements:

Dependent Coverage may be elected by

- A. Completing and signing an enrollment form within 30 days of the date the Dependent becomes eligible; and
- B. By completing any required form for payroll deduction.

Exception will be made in the definition of eligible Dependent when a court has ordered that healthcare coverage be provided for a spouse or minor child and an application for enrollment is submitted within 30 days after the issuance of a court order.

If coverage is applied for more than 30 days after the Dependent becomes eligible then the Dependent is defined as a “**Late Entrant**” and is subject to the **Late Entrant Limitation** as outlined in the section titled **DENTAL BENEFITS**.

If Plan coverage is waived by completion of a “Refusal/Waiver Form” when first eligible due to other Employer-sponsored coverage (such as coverage through other employment), and later coverage is applied for under the Plan within 30 days of such other coverage termination by submitting a new enrollment form along with proof of prior coverage acceptable to the Plan Administrator, then the **Late Entrant Limitation** requirement will not apply and Plan coverage will commence immediately upon termination of such prior coverage. However, if Plan coverage was waived for reasons other than other coverage (such as unwillingness to pay the required share of the cost of coverage), an individual may apply for Plan coverage but it will be limited in coverage for the first 6 months of coverage as outlined in the **Late Entrant Limitation**.

If a Dependent child is born after the effective date of your coverage, coverage shall take effect from and after the moment of birth, to the extent of the benefits provided herein. Coverage for such child shall continue for 30 days. After the 30-day period, coverage will terminate unless you notify the Plan Administrator of the birth of such child and agree to make any required contributions.

2. Deferral Rule:

A Dependent may be Totally Disabled on the date coverage (with respect to that particular Dependent) would otherwise take effect. The coverage of that Dependent will then be deferred until the first of the month coinciding with or next following the Dependent's cessation of Total Disability.

Note: This Rule does not apply to a newborn child.

Effective Date of Dependent Coverage. An Employee's Dependent Coverage will take effect on the day that:

1. The Eligibility Requirement is met;
2. The Employee is covered under the Plan; and
3. At least one Dependent will be covered.

When An Individual Dependent Becomes Covered For Benefits. Subject to the Deferral Rule, a Dependent will first be covered for a new benefit on the date that all of these rules are met:

1. The person is a Dependent and eligible for the new or increased coverage.
2. The Employee is covered for Dependent Coverage.
3. The enrollment requirement of the Plan is met for the benefit.

When Dependent Coverage Terminates. An Employee's Dependent Coverage will terminate on the earliest of:

1. The last day of the month an Employee's personal coverage under the Plan terminates for any reason, including death.
2. The date Dependent Coverage is terminated under the Plan.
3. The date that the Employee ceases to have a Dependent.
4. The end of the period for which a premium charge has been paid if the charge for the next period is not paid when due.

Loss of Dependent Status. Dependent Coverage will cease for a person on the first date that he ceases to be a Dependent.

Special Enrollment Rights

- a. If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependent(s) in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new Dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- b. Enrollees under these special enrollment rights will be considered a special enrollee, and not a Late Enrollee, for the purpose of determining when benefits are payable.

DENTAL BENEFITS

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid, a Covered Person must meet the deductible shown in the Summary of Benefits.

BENEFIT PAYMENT

Benefits will be paid to a Covered Person for the dental charges in excess of his deductible. Payment will be made at the rate shown under Dental Charge Benefits in the Summary of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

WAITING PERIOD

No Waiting Periods

LATE ENTRANT LIMITATION

Deferred Plan Year Enrollment: An applicant, for personal or Dependent coverage, who declined coverage, except for other group dental coverage, or fails to enroll within the first 30 days of being first eligible in the Plan, and later chooses to enroll in the Plan, will be considered a Late Entrant. A Late Entrant will be eligible for coverage the next Plan Year beginning June 1.

Late Entrant Limitations limit eligibility for any and all services to the next beginning date of the next Plan Year following enrollment.

MAXIMUM BENEFIT AMOUNT

The Maximum Dental Benefit Amount is shown in the Summary of Benefits. It is the amount of benefits that will be paid for all dental charges of a Covered Person in a Plan Year.

DENTAL CHARGES

Dental charges are the Usual, Customary and Reasonable Charges made by a Dentist or other Physician for necessary care, appliance or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Processor will apportion the overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Class I Benefits: Preventive and Diagnostic Dental Procedures

1. Oral examinations (once in a 6-month period)
2. Bitewing X-rays (once in a 2-year period)
3. Occlusal X-rays (once in a 2-year period)
4. Full mouth X-rays or Panoramic Film (once in a 5-year period)
5. Biopsy/tissue examination
6. Emergency palliative treatment
7. Prophylaxis (Cleanings) (once in a 6-month period)
8. Fluoride treatment (once per year to age 19)
9. Space maintainers (to treat premature loss of primary teeth)
10. Sealants (once in a 3-year period for children under age 17 on posterior teeth only without decay)

Class II Benefits: Basic Dental Procedures

1. Periodontic Services – Scaling and other procedures to cure or prevent diseases or defects to your gums. Periodontal Maintenance procedures (4910) is available in place of an eligible routine prophylaxis (cleaning). Coverage is contingent upon evidence of full mouth active periodontal therapy and limited to 2 allowances in a benefit period. Periodontal scaling and root planing, per quadrant (4341), each quadrant is eligible for consideration once in a two-year period.
2. Periodontal surgical procedures.
3. Endodontic Services – Root Canal Therapy and other treatment furnished to prevent or correct conditions that affect the tooth pulp, root and related tissues.
4. Simple extractions.
5. Oral Surgery – Extractions of teeth and minor oral surgery. General anesthetics and IV sedation when given as part of covered oral surgery if it is determined to be medically necessary.
6. Study models (once in a 3-year period)
7. Crown build-up on non-vital teeth
8. Recementing bridges, inlays, onlays and crowns.
9. Restorations-amalgam, synthetic, plastic or resin restorations (fillings) for treatment of cavities (decay). (If a tooth or teeth can be restored with an amalgam, any amount exceeding the cost of that material is not covered if another material is used.)

Class III Benefits: Major Dental Procedures

1. Rebasement or relining of removable dentures (once in any 2-year period, no dental benefit will be paid for repair costs that exceed 20% of the replacement cost).
2. Crowns, jackets, inlays, onlays, and cast restorations are a benefit only if teeth cannot be restored with amalgam, plastic, or composite restorations (on the same tooth, benefit only once every 5 years).
3. Installation of fixed bridges to replace one or more missing natural teeth (prosthodontic appliances are benefits once every 5 years).

4. Installation of partial dentures and complete dentures if provided to replace missing natural teeth (includes all adjustments made during the 6-month period following installation; prosthodontic appliances are benefits once every 5 years).
5. Installation of precision attachments for removable dentures, repair of full or partial dentures including addition of clasps, rests, or teeth to existing partial removable dentures.

Orthodontic Treatment and Appliances

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

These services are available for covered Dependent children under age 19 and include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause, which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the dental payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Negotiated Charge for an amalgam filling. The patient will pay the difference in cost.

PREDETERMINATION OF BENEFITS

When a course of dental treatment is expected to exceed \$300, it is required prior to receiving treatment that the claim be predetermined by the Claims Processor. **Failure to preauthorize will result in a 10% penalty against any eligible charges.** To accomplish this, it will be necessary for the Dentist to complete a claim form outlining the prescribed course of treatment and then to submit it to the Claims Processor who, in turn, will notify the Dentist of the allowable coverage under the Plan. (Please note: Predetermination is not a guarantee of payment. The patient must be eligible for coverage at the time services are rendered.)

PLAN EXCLUSIONS and LIMITATIONS.

Covered Expenses will not include and no benefits will be payable for expenses incurred:

1. For any treatment which is for cosmetic purposes.
2. To replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement of these items. Identical restorative procedures performed on the same tooth are benefits once in a two-year period.
3. For initial placement of any prosthetic appliance or fixed bridge unless such placement is needed because of the extraction of one or more natural teeth while the Covered Person is covered under this section. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth.
4. Any procedure or treatment which restores tooth structure due to attrition or abrasion or which rebuilds or maintains chewing surfaces that are damaged because teeth are out of alignment or occlusion. Treatment may include but is not limited to equilibration and periodontal splinting.
5. For any procedure before the Covered Person was covered under this section.
6. For any procedure begun after the Covered Person's insurance under this section terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Covered Person's insurance under this section terminates.
7. Replacement of lost or stolen appliances.
8. Prescribed drugs, premedication or analgesia.

9. Grafting tissues from outside the mouth to tissue inside the mouth.
10. Hospital and or surgical or treatment facility charges of any kind are excluded. Including charges by the Dentist for treatment in such a facility.
11. Anesthesia is excluded except for conscious sedation administered by a dentist when deemed medically necessary for oral surgery procedures.
12. For any treatment related to Temporomandibular Joint Dysfunction (TMJ), including but not limited to splints, occlusal guards including nightguards and athletic guards.
13. For education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.
14. For the completion of claim forms.
15. For sealants which are:
 - a. not applied to a permanent molar.
 - b. Applied after attaining the age 18
 - c. Reapplied to a molar within 3-years from the date of a previous sealant application.
16. Subgingival curettage or root planing (procedure numbers 4220 and 4341) unless the presence of periodontal disease is confirmed by both x-rays and pocket depth summaries of each tooth involved.
17. Because of an injury arising out of, or in the course of work for wage or profit.
18. By a Covered Person because of a sickness for which he or she is eligible for benefits under any Workers Compensation act or similar laws.
19. For charges for which the Covered Person is not liable or which would not have been made had no insurance been in force.
20. Services necessitated because of war or any act of war or terrorism, declared or not.
21. By a Covered Person if payment is not legal where the Covered Person is living when expenses are incurred.
22. For services that are not recommended by a physician or dentist or which are determined to not be medically or dentally necessary. This includes care and treatment that is Experimental in nature.
23. Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
24. Implants are excluded (appliances inserted into the bone or soft tissue in the jaw) or services related to implants including the removal of implants.
25. Charges for treatment by other than a licensed Dentist or Physician, except charges for dental prophylaxis performed by a license hygienist under the supervision and direction of a Dentist.
26. Services related for/to conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
27. Teeth lost before a Covered Person became covered by this Plan unless the prosthetic device which replaces such teeth also replaces one or more natural teeth, lost or extracted after the Covered Person became covered by this Plan.
28. Crowns, unless the crown restores a natural tooth while the patient is covered under the Plan for dental expense benefits and if the tooth can be restored with a material such as amalgam and the patient or the Dentist selects another type of restoration, the Covered Dental Expenses for the procedure actually performed will be limited to reasonable charges appropriate to the procedure using amalgam or similar material.
29. Partial dentures, dentures or bridgework unless the partial- denture, denture or bridgework replaces one or more natural teeth lost while the patient is covered under the Plan for dental expense benefits and the replacement occurs more than 5 years after the installation of the partial denture, and the denture or bridge cannot be repaired and was not lost or stolen.
30. Orthognathic surgery is excluded.

THIRD-PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When This Provision Applies. The Covered Person may incur dental charges due to Injuries for which benefits are paid by the Plan. The Injuries may be caused by the act or omission of another person. If so, the Covered Person may have a claim against that other person for payment of the dental charges. The Plan will be subrogated to all rights the Covered Person may have against that other person.

The Covered Person must

1. Assign to the Plan his rights to recovery when this provision applies, and
2. Repay to the Plan out of the recovery made from the other person or the other person's insurer.

Amount Subject To Subrogation or Refund. Only the amount recovered for dental charges will be subject to subrogation or refund. In no case will the amount subject to subrogation or refund exceed the amount of dental benefits paid for the Injury under the Plan.

When a right of recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the right of subrogation. In addition, the Covered Person will do nothing else to prejudice the right of the Plan to subrogate.

Defined Terms:

"Recovery" means monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injuries.

"Subrogation" means the Covered Employer's right to pursue the Covered Person's claims for dental charges against the other person.

"Refund" means repayment to the Plan for dental benefits that it has paid toward care and treatment of the Injury.

Recovery From Another Plan Under Which The Covered Person Is Covered. This right of subrogation and refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan.

COORDINATION OF BENEFITS

If a Covered Person is also covered under one or more other Plans, the benefits payable under this Plan will be coordinated with the benefits payable under those Plans.

BENEFITS SUBJECT TO COORDINATION. All benefits covered under two or more Plans will be subject to coordination.

ORDER OF BENEFIT DETERMINATION. The rules used to determine which of the Plans will pay benefits first are:

1. The benefits of a Plan with no coordination will set its benefits before a Plan with coordination.
2. The benefits of a Plan that covers the person other than as a Dependent will be set before the benefits of a Plan that covers that person as a Dependent.
3. If the claim is made for a Dependent child whose parents are not separated or divorced, the benefits of a Plan that covers a child as a Dependent of a person whose month and day of birth occurs earlier in a Calendar Year will be set before the benefits of a Plan that covers that child as a Dependent of a person whose month and day of birth occurs later in a Calendar Year.

If the month and day of birth of both parents is the same, then the Plan that has covered the parent for the longer period of time will pay its benefits first.

If the other Plan has a rule based on gender of the parent and the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

4. If the claim is made for a Dependent child whose parents are separated or divorced, benefits for the child are determined in this order:
 - a. first, the Plan of the parent with custody of the child;
 - b. then, the Plan of the spouse of the parent with custody of the child; and
 - c. finally, the Plan of the parent not having custody of the child.

But, if there is a court decree that sets financial responsibility for the medical, dental or other health care expenses for the child, the benefits of a Plan that covers the child as a Dependent of the parent who is responsible shall be set before the benefits of any other Plan that covers the child as a Dependent child.

5. The benefits of a Plan that covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) will be set before those of a Plan that covers that person as a laid off or retired Employee (or as that Employee's Dependent). If the other Plan does not have this rule, and, as a result the Plans do not agree on the order of benefits, then this rule is ignored.
6. When the rules above do not apply, the benefits of a Plan that has covered the person for the longer period of time will be set before the benefits of a Plan that has covered the person the shorter period of time.

When the benefits of this Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. PESC Administrators may give or get from any other organization or person any information necessary to decide whether coordination applies. This may be done without the consent of the Covered Person. Any person claiming benefits under this Plan will be required to give PESC Administrators any information necessary to coordinate benefits.

Facility of Payment. This Plan may repay other Plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery. This Plan may pay benefits that should be paid by another Benefit Plan. In this case, this Plan may recover the amount paid from the other Benefit Plan or the Covered Person. That repayment will count as a valid payment under the other Benefit Plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

CONTINUATION OPTION

CONTINUATION COVERAGE (COBRA) NOTICE AND STATEMENT OF RIGHTS UNDER THE XYZ CORPORATION DENTAL PLAN.

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, which is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law, and if it is found to be incomplete or in conflict in any way with the law or changes to the law, the law will prevail. COBRA continuation coverage is available for certain Employer-provided benefits. Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if part of the Employer's Plan) are not eligible for continuation under COBRA.

If retired Employees are eligible and covered under the Plan, such retired Employees are also "Employees" for purposes of COBRA continuation coverage. Also, certain additional COBRA rights apply to such retirees and their covered Dependents with regard to an Employer's bankruptcy. Anywhere "retirees" are referenced herein, it means only those retired Employees who were covered under the Plan.

QUALIFIED BENEFICIARY: Qualified Beneficiary is an individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse or child of a covered Employee.

Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. For such child, the Employee's Qualifying Event and resultant continuation coverage period also applies to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

There is an exception to the Qualified Beneficiary rules: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

QUALIFYING EVENTS: Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage, and would be considered a "Qualifying Event" under COBRA:

- 1) voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;
- 2) reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA leave;
- 3) for an Employee's spouse or child, Employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his or her Medicare coverage is in effect;
- 4) for an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;
- 5) for an Employee's spouse or child, the death of the covered Employee;
- 6) for an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit);
- 7) for retirees and their Dependent spouses and children, loss of Plan coverage due to the Employer's filing of a bankruptcy proceeding under Title 11 of the U.S. Bankruptcy Code. In order for a Qualifying Event to occur, the Employee must have retired on or before the date of substantial elimination of the Plan's benefits and must be covered under the Plan on the day before the bankruptcy proceedings begin. "Substantial elimination" of the Plan's benefits must occur within 12 months before or after the bankruptcy proceedings begin.

Your Qualifying Event entitles you and/or your covered Dependents to continue coverage for the period of 18 months beginning on the date of the Qualifying Event. However, under the following circumstances, you may

qualify for extended continuation *if any of the following occurs during the original 18-month continuation period:*

- a). You cease to be a Dependent child as defined by the Plan; or
- b). The Employee dies or becomes entitled to Medicare; or
- c). The Employee and spouse are divorced or legally separated.

In these situations, the extended period will be for a maximum of 36 months, beginning with the commencement date of your original 18 months of continuation coverage. You and/or your covered Dependents must provide written notice to the Employer listed above of the occurrence of these events before the end of the original 18-month continuation period.

Any qualified beneficiary who is determined to have been disabled (under Title II or XVI of the Social Security Act) *at any time during the first 60 days of COBRA* may be entitled to extend an 18-month continuation coverage period to 29 months. This extension only applies if, within 60 days of the date of a written disability determination from the Social Security Administration (SSA) and prior to the end of the 18-month continuation coverage period, you provide a copy of the disability determination letter to the Employer listed above. The 11-month disability extension also applies to non-disabled family members who are qualified beneficiaries due to the termination or reduction in hours of employment. Disability extended coverage will cease for such an individual if there is a determination that the individual is no longer disabled. Please note that federal law requires you to inform the Employer listed above within 30 days of a SSA determination that the individual is no longer disabled.

You may lose your Continuation Coverage before the expiration of the 18 months or 36 months described above (or 29 months, if applicable) for any of the following reasons:

- 1. If any required premium payment is not paid in full when due (see failure to pay rules, below), coverage will cease for you, your spouse and Dependent children (if any).
- 2. If you, your spouse or your Dependent children (if any) become covered under another group health plan that does not contain any applicable exclusion or limitation for any pre-existing condition of the Qualified Beneficiary, after the election of COBRA benefits, coverage will cease for each individual so covered.
- 3. If all of the above Employer listed group health plans are terminated, coverage will cease for you, your spouse and Dependent children (if any).
- 4. If coverage was extended to 29 months due to disability, coverage will cease for such individual if there is a determination that the individual is no longer disabled. See above.
- 5. If you, your spouse or your Dependent children (if any) become eligible for coverage under Medicare, coverage will cease for each individual so eligible. However, if your Medicare Entitlement for Parts A or B should pre-date the Covered Person's termination or reduction in hours, COBRA coverage will not be denied. If you are age 65 or over and receive or have applied for Social Security (or qualify for Social Security at an earlier age due to a disabling condition) you are considered eligible for Medicare.

NOTIFICATION OF RIGHTS: The Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights within 14 days of receipt of notice of a Qualifying Event. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred which permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Employer or Plan Administrator within 60 days of a Qualifying Event that is: (1) a Dependent child's ceasing to be eligible under the requirements of the Plan, or (2) the divorce or legal separation of the Employee from his/her spouse.

ELECTION: COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

Open Enrollment rights that allow Non-COBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though Active Employees not participating in the Plan have such rights under HIPAA.

OUTSIDE INQUIRIES: The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period, and any period for which the Plan has not received premium payment(s).

STATEMENT OF RIGHTS HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

1. Right to Request a Certificate of Coverage

IMPORTANT NOTICE OF YOUR RIGHT TO DOCUMENTATION OF HEALTH COVERAGE

Recent changes in Federal law may affect your health coverage if you are enrolled or become eligible to enroll in health coverage that excludes coverage for pre-existing medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll for coverage. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (or 18 months for Late Enrollees). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. You are entitled to a certificate that will provide evidence of your prior health coverage. Such certificate will inform your new insurer that you have met all or a part of your one-time pre-existing conditions waiting period. If you have not had prior coverage for the full period needed to satisfy the pre-existing waiting period, you will be given credit for all time served toward your pre-existing waiting period. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion. You may contact your State Insurance Department for further information.

You have the right to receive a certificate of prior health coverage since July 1, 1996. You may need to provide other documentation for earlier periods of health care coverage. Check with your new Plan Administrator to see if your new Plan excludes coverage for pre-existing conditions and if you need to provide a certificate or other documentation of your previous coverage.

2. Portability of Health Coverage

HIPAA enables individuals to obtain coverage more readily when changing jobs and moving from one group health plan to another. Under HIPAA, Covered Persons may receive credit for prior creditable coverage under a qualified group plan as long as coverage has not lapsed longer than 63 days. You may have a lapse in coverage for up to 62 days without losing your prior creditable coverage. A waiting period or affiliation period for an HMO is not considered a break in coverage.

Creditable coverage includes any group plan or policy, Medicare, Medicaid, CHAMPUS, Indian Health Service Plan or State High Risk Pool.

Creditable coverage may assist you in gaining uninterrupted future coverage without a pre-existing condition waiting period. Group health plans may refuse or limit coverage on a new enrollee for up to 12 months, or 18 months for Late Entrants, for a health condition that was diagnosed or treated within the six-month period prior to enrollment.

The period of any pre-existing condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage the individual has as of the enrollment date.

Effective January 1, 1998, pregnancies may not be excluded as a pre-existing condition. In addition, pre-existing clauses may not be applied to newborns or adopted children who become covered within 30 days of birth, adoption or placement. This protection is lost if there is a break in coverage.

3. Certificates

You have a right to request a Certificate of Coverage to qualify for pre-existing conditions portability or to assist you in gaining new coverage elsewhere.

Certificates must be provided for the following circumstances:

1. an individual loses Plan coverage,
2. an individual becomes covered under COBRA,
3. COBRA coverage ceases, or they are requested by the individual no later than 24 months after coverage ended. This obligation extends for 24 months from the date of the individual's loss of coverage.

Individuals should request that the prior health plan send certificates directly to the new Employer for proper credit. It is the responsibility of the Covered Person(s) to provide this information to the new health plan.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. XYZ CORPORATION Dental Benefits Plan is the benefit Plan of XYZ CORPORATION, the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. The Plan Administrator is appointed by XYZ CORPORATION and serves at its convenience. If the Plan Administrator resigns, dies or is otherwise removed from the position, XYZ CORPORATION shall appoint a new Plan Administrator as soon as reasonably possible.

DUTIES OF THE PLAN ADMINISTRATOR

1. To administer the Plan in accordance with its terms.
2. To decide disputes which may arise relative to an Employee's rights.
3. To keep and maintain the Plan documents and all other records pertaining to the Plan.
4. To appoint a Claims Processor to pay claims.
5. To perform all necessary reporting as required by ERISA.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets and renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his duties and responsibilities for the purpose of providing benefits to the Employee and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties, which must be carried out:

1. With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
2. By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
3. In accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A “named fiduciary” is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment of the procedures; or
2. The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS PROCESSOR IS NOT A FIDUCIARY. A Claims Processor is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee or Dependent Coverage: Funding is derived solely from the funds of the Covered Employer.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Processor.

BINDING ARBITRATION

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this policy or breach thereof, or in relation to care or delivery of, care including any claim based on contract, tort, or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court.

Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The arbitration is begun by the Covered Person making written demand on the Plan Administrator. The arbitration will be conducted by the American Arbitration Association according to its commercial rules of arbitration. The arbitration shall be held in the State of California.

The Covered Person and Plan Administrator agreed to be bound by the arbitration provision and acknowledge that they are each giving up its right to a trial by court or jury.

The arbitration findings will be final and binding except to the extent that California or Federal Law provides for the judicial review of arbitration proceedings.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Covered Employees are limited to expenses incurred before termination.

The Covered Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

ROLE OF HEALTH INSURANCE ISSUERS

- a. Benefits are paid out of the general assets of the Plan Sponsor. Employee contributions may also be used in part toward the payment of claims. There is no special fund or trust or insurance policy from which benefits are paid. The Plan Sponsor may, at its discretion, purchase stop loss insurance protection for catastrophic claims. This, however, does not absolve the Plan Sponsor from the claim paying responsibility of this Plan.
- b. The Plan Sponsor has hired a professional claims administrator to process claims. Their address can be found in the General Information Section of this document. This claims administrator processes claims, then requests and receives funds from the Plan Sponsor to pay the claims, and makes payment on the claims to hospitals and other providers. The Plan Sponsor is ultimately responsible for providing Plan Benefits, not the stop loss carrier or claims administrator.

STATEMENT OF EMPLOYEE RETIREMENT INCOME SECURITY ACT RIGHTS

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

Examine without charge, at the Plan Administrator's office, and at other locations during normal business hours, all Plan documents including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. 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 financial report.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the Employee Benefit Plan. These persons are referred to as fiduciaries. They have a duty to act prudently and in the interest of the Plan participants and their beneficiaries.

No one, including your Employer, may fire or discriminate against you to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered. Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay you up to \$100 a day until you receive the materials, unless they were not sent due to reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse Plan money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees.

If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your suit was frivolous), the court may order you to pay court costs and fees. If you have any questions about this statement or your rights under ERISA, you should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquires, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C., 20210.

The Los Angeles Regional Office is located at 790 E. Colorado Blvd., Suite 514, Pasadena, CA 91101. Telephone (818) 583-7862.