

United Concordia
Concordia Preferred Dental Plan

GROUP DENTAL PROGRAM EVIDENCE OF
COVERAGE AND SUMMARY PLAN
DESCRIPTION

For the Employees of
County of Riverside
Group Numbers: 860127-000, 011, 012, 015



SUMMARY PLAN DESCRIPTION

COUNTY OF RIVERSIDE GROUP DENTAL PLAN

Concordia Preferred

Introduction

We all need regular dental care. Prevention through early, quality care helps to keep your family and you in good dental health. Being in good dental health may reduce your out-of-pocket expenses in the long term. This is why your employer chose Concordia Preferred. The goal is to help you avoid complex, costly dental procedures.

This Plan/Summary Plan Description is written in an easy-to-understand way to explain the County of Riverside Group Dental Plan ("the Plan"), and to give you information concerning the Plan which you may need in the future. If you have any questions after reading this Plan/Summary Plan Description, feel free to contact the Human Resources Department or United Concordia.

The Plan is intended to operate to provide dental benefits for eligible employees and their covered dependents.

Definitions

Certain words that you will see in this booklet have specific meanings. These definitions should make your dental program easier to understand.

Annual deductible - the amount you must pay for dental care each year before United Concordia's benefits begin.

Attending Dentist's Statement - also referred to as a claim form, the form used by a dentist to request payment for dental treatment or predetermination for proposed dental treatment.

Benefits - those dental services available under the Contract and which are described in this booklet.

Categories of benefits:

Diagnostic - procedures to help the dentist evaluate your dental health to determine necessary treatment.

Preventive - procedures to prevent dental disease (cleanings, for example).

Basic - procedures necessary to restore the teeth (other than crowns or cast restorations), oral surgery, endodontic (root canals) and periodontic (gum) procedures.

Major - procedures to include crowns and cast restorations, inlays, onlays, prosthodontics (bridges and dentures to replace missing teeth).

Orthodontic — procedures involving appliances (such as braces) or surgery to realign teeth which do not function properly.

Contract - the written agreement between your employer or sponsoring group and United Concordia to provide dental benefits. The Contract, together with this booklet, forms the terms and conditions of the benefits you are provided.

Covered services - those dental services to which United Concordia will apply benefit payments, according to the Contract.

Participating Dentist - a dentist who has signed a contract with United Concordia. These dentists agree to accept United Concordia's allowance for covered services as payment in full. They further agree not to hold the member responsible for the difference between their fee and United Concordia's allowed charge.

Eligible Dependent - any of the dependents of an Eligible Employee who are eligible to enroll for benefits in accordance with the conditions of eligibility outlined in this booklet.

Eligible Employee - any group member or employee who is eligible to enroll for benefits in accordance with the conditions of eligibility outlined in this booklet.

Enrollee - an eligible Employee or Eligible Dependent enrolled to receive benefits or a person who chooses to pay for optional continuation of coverage (COBRA participant).

Maximum - the greatest dollar amount United Concordia will pay for covered procedures in any calendar year or lifetime for orthodontic benefits. All benefit dollars paid accumulate toward the annual maximum.

Plan Year - means each 12 month period from January 1 until December 31, during which your program is in effect.

WHO IS ELIGIBLE FOR COVERAGE

Employee Eligibility

You are eligible to participate in the benefits program if you are a regular County employee scheduled to work at least 20 hours per week. Your bargaining unit determines which plan options are available to you. For more information about your benefit options, please review the information provided in the County of Riverside annual enrollment guide.

Dependent Eligibility

You may enroll your eligible dependents in your medical, dental and vision coverage. Your eligible dependents* include:

- Your legal spouse/registered domestic partner (see information below about domestic partner eligibility)
- Your and /or your spouse/domestic partner's dependent natural children, adopted children, foster children, and stepchildren under age 23 and who has never been married
 - Any child, who is under age 23 and has never been married, for whom you have legal custody, have been required to cover under your medical plan as part of a qualified medical child support order or who resides with you (generally in the absence of the natural or adoptive parent) and who is economically dependent upon you

- An otherwise eligible child past age 23 if the child is incapable of self-support because of a mental or physical handicap and you continue to claim the child as a dependent on your federal income tax return

* Important notes about dependent eligibility:

1. It is against the law to enroll ineligible family members. If you do, you may have to pay for all costs incurred by the ineligible dependent from the date the coverage began.
2. If you do not add newly eligible family members to your health plan within the 60-day period of eligibility, you may enroll them during any future annual enrollment period.
3. Your former spouse, parents, parents-in-law, other relatives, and non-disabled children age 23 and over are not eligible for coverage under your healthcare plans.
4. You must drop coverage for your enrolled spouse/domestic partner or dependent child when he/she loses eligibility (e.g., divorce, your child attains age 23, or marries).

REQUIRED PROOF OF ELIGIBILITY

You will need to provide proof of eligibility each time you request a spouse, domestic partner, or child to be added to your medical, dental, or vision plan. Once you have completed your enrollment election form, submit these documents to your Department Representative.

Spouse

A copy of your certificate of marriage and your spouse's social security number must be submitted at the time your spouse is enrolled. If a marriage certificate is not available to meet the 60-day enrollment period or annual enrollment deadline, an Affidavit of Marriage Form must be completed and notarized.

Domestic Partner

If you are in a domestic partnership and both of you meet all of the criteria listed below, you may enroll your domestic partner and his/her legal dependent children in your medical, dental, and/or vision plans. A domestic partnership is defined as two people who both:

- Are at least 18 years of age, unmarried, and not a blood relative close enough to bar marriage in the State of California, and
- Live in a mutually exclusive relationship in which you are jointly responsible for each other's welfare and financial obligations, and
- Live in the same principal residence and intend to do so indefinitely, and
- Are in a domestic partnership as attested by both of you through a signed California Declaration of Domestic Partnership Agreement.

Based on state law (AB 26 and AB25), the following partners are eligible to register with the state:

- Specified same-sex domestic partnership between persons who are both at least 18 years of age, and
- Specified opposite-sex domestic partnerships where one person is over the age of 62.

Children

You may enroll children (natural, adopted, or step children) who are under the age of 23 and who have never been married in the medical, dental, and vision plans. These children are not required to be enrolled in school and do not need to reside with the employee to be eligible. Additionally, no proof of eligibility is required for natural children, adopted children, or stepchildren.

An employee may enroll another person's child under the age of 23, who has never married, if the child is economically dependent on the employee. To verify eligibility, an Affidavit of Eligibility Form must be completed and submitted at the time of enrollment.

- The employee has been granted legal custody or joint legal custody of the child

- The child resides with the employee or annuitant (generally in the absence of the natural or adoptive parent)
- The child who is the natural, adopted, stepchild, or economically dependent child of the employee's domestic partner

Disabled Children (Age 23 or Over)

An employee may enroll a disabled child who is age 23 or over upon the initial enrollment or as a CONTINUATION of coverage beyond age 23. The employee must complete and submit a Member Questionnaire for the Disabled Dependent Form and a Medical Report Form. The Medical Report Form must be completed by the child's physician, and must be submitted to the County of Riverside for processing. These forms must be received within 60 days of the initial enrollment or the child/s 23rd birthday. The enrollment will be processed, but it will be contingent upon approval of the disability. If the dependent child is later deemed ineligible for benefits, the child's coverage will be terminated on a retroactive basis and the employee will be responsible for any medical services rendered.

ENROLLMENT

If you are a newly hired or newly eligible employee, you may elect to enroll within 60-days of your hire date or eligibility. All coverage will be effective the first day of the month, following your employer's receipt of your election.

Making Mid-Year Changes

Each year your elections stay in effect from January 1, through December 31, as long as you remain eligible for benefits. During annual enrollment, you have the opportunity to change your coverage elections for the following plan year. However, after the close of annual enrollment you can make benefit changes ONLY if you have a qualified status change. Qualified status changes include:

- Marriage, or gaining a domestic partner
- Divorce, or separation from domestic partner
- Birth or adoption of a child
- Death of a spouse or a child
- Change in spouse's employment
- Significant changes in your spouse's employer's medical coverage
- Child's loss of eligibility due to age, student status, or marital status
- Full-time/part-time employment status change that results in an insurance eligibility change
- Commencement of or return from an unpaid leave of absence

If one of the above events occurs, and you want to make a benefit change consistent with the specific event, you must submit a new Election Form indicating your new coverage elections within 60-days of the event to your employer.

When You Are No Longer Covered

- 1. If you stop working for your employer, your dental coverage will end on date reported to United Concordia by County of Riverside, unless you qualify for and pay for OPTIONAL CONTINUATION OF COVERAGE. Your dependents' coverage ends when yours does, or as soon as they are no longer dependents, unless they choose to pay for OPTIONAL CONTINUATION OF COVERAGE.**
- 2. When the contract between United Concordia and County of Riverside is discontinued or canceled, your coverage ends immediately.**

- 3. When you are on strike, layoff or leave of absence, United Concordia does not cover any dental services received by you or your dependents.**

Canceling this program

United Concordia may cancel this program only on an anniversary date (period after the program first takes effect or at the end of each renewal period thereafter), or any time your group does not make payment as required by the contract. If the program is canceled, you and your dependents have no right to renewal or reinstatement of your benefits.

How Concordia Preferred Works

Choice of Dentist

You may go to any dentist for services covered by the Plan. However, you will have a cost advantage if you choose to go to a participating Concordia Preferred dentist. You will pay only the coinsurance amount that your plan specifies. Concordia Preferred network dentists' will also fill out and send claim forms for you.

If you go to a dentist who is not in the Concordia Preferred network, you may have to pay the dentist up-front. You may also have to send in your claim yourself, and then wait for the Claims Administrator to reimburse you. Please note, however, there is a section on the claim form which allows you to authorize United Concordia to make payment directly to the dentist, even if they are non-participating. Once signed, we will process the claim with the appropriate payment sent to the dentist. You will have to pay the difference between the dentist's charge and the amount that United Concordia allows. This is *in addition to* any coinsurance payment that is applicable.

To find a participating dentist, visit *Find a Dentist* on United Concordia's website at www.ucci.com or telephone United Concordia's Interactive Voice Response System at 1-800-332-0366. When you visit the dental office, let your dentist know that you are covered under a United Concordia program. If your dentist has questions about your eligibility or benefits, instruct the office to call United Concordia's Interactive Voice Response System at 1-800-332-0366 or visit Dental Inquiry at www.ucci.com.

Identification Cards

You will receive Concordia Preferred ID cards when you become a member. You may call United Concordia at 1-800-332-0366 to request new cards if you lose your cards. Show your Concordia Preferred ID card when you go to your dentist's office.

Coinsurance

You should visit the dentist regularly. This is why check-ups, cleanings and x-rays require either a small coinsurance payment or no payment at all. Your payment depends on your plan. Cleanings and x-rays are "preventive and diagnostic" services. You may have a payment for other services. (Please see the attached Schedule of Benefits.) You must pay the coinsurance amount once you receive a bill for it.

Predetermination of Benefits

A predetermination is a review in advance of treatment by the Claims Administrator to determine

eligibility and coverage for planned services in accordance with the Schedule of Benefits and the Plan allowance. Predetermination is not required to receive a benefit for any service under the Plan. However, it is recommended for extensive, more costly treatment. A predetermination gives you and your dentist an estimate of what your coverage is and how much your share of the cost will be for the treatment being considered.

A predetermination does not guarantee payment. It is an estimate of the amount United Concordia will pay if you are eligible and meet all the requirements of your program at the time the treatment you have planned is completed.

In order to have services predetermined, you or your dentist should submit a claim form showing the planned procedures omitting the dates of services. Be sure to sign the predetermination request. Substantiating material such as radiographs and periodontal charting may be requested by United Concordia to estimate benefits. United Concordia determine benefits payable, taking into account exclusions and limitations and alternate treatment options based upon accepted standards of dental practice. You and your provider, if participating in United Concordia's network, will receive an explanation of the estimated benefits.

When the services are performed, simply have your dentist call United Concordia's Interactive Voice Response System at 1-800-332-0366, or fill in the dates of service for the completed procedures on the predetermination notification and re-submit to United Concordia for processing. Any predetermination amount estimated by United Concordia is subject to continued eligibility of the patient. United Concordia may also make adjustments at the time of final payment to correct any mathematical errors, apply coordination of benefits, and comply with the member's Plan in effect and remaining program maximum dollars at date of service.

Course of Treatment

A course of treatment is a planned program of one or more services or supplies for the treatment of a dental condition. The course of treatment starts as of the date that a dentist first does something to correct or treat the diagnosed dental condition.

Alternate Treatment

There are often several ways to treat a dental condition. For example, a filling of a crown can restore a tooth, or a fixed bridge or a partial denture can replace missing teeth. An Alternate Benefit Provision (ABP) will be applied if a dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The Plan will pay for the lesser benefit, professionally acceptable procedure. The ABP does not commit you to the less costly treatment. If you and your dentist choose the more expensive treatment, you are responsible for the additional charges beyond those allowed for the less expensive procedure under the ABP.

BENEFITS

Your dental program covers several categories of benefits, when the services are provided by a licensed dentist, and when they are necessary and customary under the generally accepted standards of dental practice. After you have satisfied any deductible requirements, United Concordia will provide payment for these services at the percentage indicated up to a maximum of \$ 1,200 for each enrollee in each calendar year if a Participating Dentist is used. If you use a non-participating dentist, the calendar year maximum is \$1,000. Payments for orthodontic benefits are limited to a lifetime maximum of \$1,000.

United Concordia's payments are based upon the maximum allowed charge for a covered dental service. Participating dentists accept the maximum allowed charge as payment in full.

I. DIAGNOSTIC AND PREVENTIVE -
100% if provided by a Participating Dentist
100% if provided by other dentists

Diagnostic - oral examination, x-rays, diagnostic casts, biopsy/tissue examination, emergency treatment, consultation by a specialist.

Preventive - prophylaxis (cleaning) fluoride treatment, space maintainers.

Limitations

- a) Oral examinations are benefits only twice in a calendar year.
- b) Prophylaxes (cleanings), fluoride treatments or procedures that include cleanings are benefits only twice in a calendar year.
- c) Unless special need is shown, full-mouth x-rays are benefits only once in a three-year period.
- d) Supplementary bitewing x-rays are benefits only twice in any calendar year.

II. BASIC SERVICES-
80% if provided by a Participating Dentist
50% if provided by other dentists

Oral surgery - extractions and certain other surgical procedures, including pre- and post-operative care.
Restorative - amalgam, synthetic, plastic or resin restorations (fillings) for treatment for cavities (decay).
Endodontic - treatment of the tooth pulp.
Periodontic - treatment of the gums and bones that support the teeth
Sealants - topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay.

Limitations

- a) **Periodontal procedures that include cleanings are subject to the same limitations as other cleanings; i.e., cleanings of any kind are benefits no more than twice in any calendar year.**
- b) **Sealant benefits are limited to eligible dependent children under age 14. Sealant benefits include the application of sealants only to permanent posterior molars without caries (decay), without restorations, and with the occlusal surface intact.**
Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.

III. MAJOR SERVICES - CROWNS, INLAYS, ONLAYS, BRIDGES & DENTURES
60% if provided by a Participating Dentist
50% if provided by other dentists

Crowns, inlays, onlays and cast restorations are benefits only if they are provided to treat cavities that cannot be directly restored with amalgam, synthetic, plastic or resin fillings.

Construction or repair of fixed bridges, partial dentures and complete dentures are benefits if provided to replace missing, natural teeth.

Limitations

- a) **Crowns, inlays, onlays and cast restorations are benefits on the same tooth only once every five**

years.

- b) **Prosthodontic appliances are benefits only once every five years unless United Concordia determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory.**
- c) **United Concordia will pay the above percentage for a standard partial or complete made from accepted materials and by conventional methods.**
- d) **Implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture) are not covered by your program. However, if implants are provided along with a covered prosthodontic appliance, United Concordia will allow the cost of a standard partial or complete denture toward the cost of the implants and the prosthodontic appliances when the prosthetic appliance is completed. If United Concordia makes such an allowance, we will not pay for any replacement for five years following the completion of the service.**

IV. ORTHODONTIC -

50% if provided by a Participating Dentist

50% if provided by other dentists

Procedures using appliances or surgery to straighten or realign teeth, which otherwise would not function properly.

Limitations

- a) **If orthodontic treatment is begun before you become eligible for coverage, United Concordia's payments will begin with the first payment due to the dentist following your eligibility date.**
- b) **United Concordia's payments will stop when the first payment is due to the dentist following either a loss of eligibility, or if treatment is ended for any reason before it is completed.**
- c) **X-rays and extractions that might be necessary for orthodontic treatment are not covered by orthodontic benefits, but may be covered under diagnostic and preventive or basic benefits.**

EXCLUSIONS/SERVICES WE DO NOT COVER

United Concordia covers a wide variety of dental care expenses, but there are some services under this plan for which we do not provide benefits. It is important for you to know what these services are before you visit your dentist.

United Concordia does not provide benefits for:

- 1. Services for injuries covered by Workers' Compensation or Employer's Liability Laws or services which are paid by any federal, state, or local government agency, except Medi-Cal benefits.**
- 2. Services for cosmetic purposes or for 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.**
- 3. Treatment which restores tooth structure that is worn; treatment which rebuilds or maintains chewing surfaces that are damaged because the teeth are out of alignment or occlusion; or**

treatment which stabilizes the teeth. Examples of such treatment are equilibration and periodontal splinting.

4. Any single procedure, bridge, denture or other prosthodontic service which was started before you were covered by this program.
5. Prescribed drugs, premedication, or analgesia.
6. Experimental procedures.
7. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
8. Anesthesia, except for general anesthesia given by a dentist for covered oral surgery procedures.
9. Grafting tissues from outside the mouth to tissue inside the mouth ("extraoral grafts"), implants (materials implanted into bone or soft tissue) or the removal of implants.
10. Services for any disturbances of the jaw joints (temporomandibular joints or "TMJ") or associated muscles, nerves or tissues.
11. Charges for replacement or repair of an orthodontic appliance paid in part or in full by this program.
12. Services which are not prescribed and/or rendered by or under the direct supervision of a dentist.
13. Charges for broken appointments.

DEDUCTIBLE

You must pay the first \$50 of covered services for each enrollee (maximum of 3) in your family in each calendar year. The deductible does not apply to services provided by a Participating Dentist.

COVERED FEES

It is to your advantage to select a dentist who is a United Concordia Participating Dentist, since a lower percentage of the dentist's fees may be covered by the program if you select a dentist who is not participating.

A list of Participating Dentists is available in on the Internet at our website www.ucci.com or by calling 1-800-332-0366.

CHOOSING YOUR DENTIST

More than 11,000 dentists in active practice in California are United Concordia dentists. You are free to choose any dentist for treatment, but it is to your advantage to choose a Participating Dentist. Participating Dentists have claim forms on hand and will complete and submit the forms to United Concordia free of charge.

If you choose a United Concordia dentist, you will receive all the advantages of going to a Participating Dentist, and you will have a higher level of benefits for certain services. If you go to a non-participating dentist, United Concordia cannot assure you what percentage of the charged fee may be covered.

Services may be obtained from any licensed dentist during normal office hours. Emergency services are available in most cases through an emergency telephone exchange maintained by the local dental society which is listed in the local telephone directory.

SAVING MONEY ON YOUR DENTAL BILLS

You can keep your dental expenses down by:

1. Comparing the fees of different dentists;
2. Using a United Concordia Participating Dentist;
3. Having your dentist obtain predetermination from United Concordia for any treatment over \$300;
4. Visiting your dentist regularly for checkups;
5. Following your dentist's advice about regular brushing and flossing;
6. Not putting off treatment until you have a major problem.

YOUR FIRST APPOINTMENT

During your first appointment, be sure to give your dentist the following information:

1. Your United Concordia group number (on your ID Card);
2. Your employer's name;
3. Primary enrollee's social security number (which may also be used by dependents);
4. Primary enrollee's date of birth;
5. Any other dental coverage you may have.

PAYMENT

United Concordia will pay Participating Dentists directly. Our agreement with our Participating Dentists makes sure that you will not be responsible to the dentist for any money we owe. If you choose a non-participating dentist, United Concordia will make payment to you. However, payments are assignable (in other words, United Concordia will make payment directly to your dentist if you sign the claim form where it indicates "Assign Benefits").

United Concordia does not make or pro-rate payments for treatment in progress or incomplete procedures. The date the procedure is completed governs the calculation of any deductible (and determines when a charge is made against any maximum) under your program.

If there is a difference between what your dentist is charging you and what United Concordia says your portion should be, or if you are not satisfied with the dental work you have received, contact United Concordia's Customer Service Department. We may be able to help you resolve the situation.

IF YOU HAVE QUESTIONS ABOUT SERVICE FROM A PARTICIPATING DENTIST

If you have questions about the services you receive from a Participating Dentist, we recommend that you first discuss the matter with your dentist. If you continue to have concerns, call our Customer Service Department at 1-800-332-0366. If appropriate, United Concordia can arrange for you to be examined by one of our consulting dentists in your area. If the consultant recommends the work be replaced or corrected, United Concordia will intervene with the original dentist to either have the services replaced or corrected at no additional cost to you or obtain a refund. In the latter case, you are free to choose another dentist to receive your full benefit.

COMPLAINT PROCEDURE, CLAIMS APPEAL AND ARBITRATION

If you have any questions about the services you receive from a United Concordia Participating Dentist, we recommend that you first discuss the matter with your dentist. If you continue to have concerns call us at 1-800-332-0366. We will provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for denial. If you have a question or complaint regarding eligibility, the denial of dental services or claims, the policies, procedures and operations of United Concordia, or the quality of dental services performed by a United Concordia Participating Dentist, you may contact us at 1-800-332-0366. You have 60 days after you receive notice of denial to appeal. If you write you must include the name of the patient, the group name and number, the employee's name and social security number and your telephone number on all correspondence. You should also include a copy of the treatment form, Explanation of Benefits and any other relevant information. Clearly explain your complaint and send it to us at: United Concordia, 21700 Oxnard Street, Suite 500, Woodland Hills, CA 91367.

We will review your complaint and will respond to it within 30 days unless more information or time is needed to resolve the matter. We may need more time if your complaint is referred to a dental consultant or to a peer review committee. If a referral is necessary, a reply will be sent to you in no more than 120 days after we receive your complaint. We will respond within five days of receipt to complaints involving imminent and serious threat to a patient's health.

If you have completed our grievance process or if you have been involved in our grievance process for 60 days, you may file a complaint with the Department of Corporations if we have not satisfactorily resolved your grievance. You may immediately file a complaint with the Department in an emergency situation.

The California Department of Corporations is responsible for regulating health care service plans. The Department has a toll-free number (1-800-400-0815) to receive complaints regarding health plans. If you have a grievance against the health plan, you should contact the plan and use the plan's grievance process. If you need the Department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by the plan, you may call the Department's toll-free telephone number.

IF YOU HAVE ADDITIONAL COVERAGE

It is to your advantage to let your dentist and United Concordia know if you have dental coverage in addition to this program. Most dental carriers cooperate with one another to avoid duplicate payments, but still allow you to make use of both programs—sometimes paying 100% of your dental bill. In all cases, payments are not to exceed the entire fee charged by a dentist.

Be sure to advise your dentist of all programs under which you have dental coverage and have him or her complete the dual coverage portion of the Attending Dentists Statement, so that you will receive all benefits to which you are entitled.

Extension of Benefits

If the Concordia Preferred program for you or a dependent is terminated (unless the termination is due to nonpayment of premiums or co-payments, or fraud on your part), coverage for completion of a dental procedure that requires two or more visits on separate days to a dental office will extend for ninety (90) days after termination.

In the case of orthodontic treatment, your coverage will extend for sixty (60) days if the orthodontist has agreed to or is receiving monthly payments. Coverage extends either to the end of the quarter in progress or for sixty (60) days, whichever period is greater, if the orthodontist has agreed to or is receiving quarterly payments.

COBRA Continuation Coverage

Notwithstanding the termination provisions of the Plan described above, if the Employer normally employed 20 or more employees on a typical business day during the preceding calendar year, continuation coverage shall be provided under the Plan in accordance with ERISA Sections 601 through 608, Code Section 4980B, and Title XXII of the Public Health Services Act ("COBRA continuation coverage"). The terms of such COBRA continuation coverage are described below:

- (a) COBRA continuation coverage shall be offered under the following circumstances ("qualifying events") if participation under the Plan ordinarily would terminate as a result of such circumstances: (1) the Participant's termination of employment (other than by reason of such Participant's gross misconduct) or reduction of work hours to a level that would exclude him and his family from the Plan; (2) the Participant's divorce or legal separation; (3) death of the Participant; (4) the Participant's entitlement to Medicare benefits; (5) a dependent child ceasing to qualify as a "dependent" eligible for coverage under the terms of the Plan; or (6) the commencement by the Employer on or after July 1, 1986 of a Title 11 bankruptcy proceeding. (Item (6) affects only retired Participants, their Spouses and Dependents.)
- (b) COBRA continuation coverage shall be offered only to the Participant and/or his Spouse and his Dependents who were covered under the Plan on the day before the qualifying event occurred and who lose coverage under the Plan on account of the qualifying event ("qualified beneficiaries"). The qualified beneficiary shall be entitled to elect only the type of coverage he was receiving under the Plan at the time of the qualifying event. The right to elect core coverage, i.e., basic hospitalization and major medical coverage, shall be offered separately. Non-core coverage will not be offered separately from core coverage under the Contract.
- (c) In the case of qualifying events described in (a)(2) or (5) above, the Participant or his family must notify the Employer of the qualifying event within 60 days of the date of the event. In all other cases, the Employer shall be deemed to be notified of the qualifying event. Within 14 days of such notification, the Employer shall provide the Participant and/or his family with a notice of the right to elect COBRA continuation coverage.
- (d) The Participant, his Spouse, or his Dependent may elect COBRA continuation coverage within 60 days of the latter of the date of the qualifying event, or the date to the notice from the Employer to qualified beneficiary. Each qualified beneficiary may make a separate election for COBRA continuation coverage. If an election is made within the 60-day period, the Plan shall permit payment for COBRA continuation coverage during the period preceding such election to be made not less than 45 days after the date of the election. If the election to continue coverage is not made within the above 60-day period,

then no further opportunity to continue coverage will be extended to the Participant, his Spouse or his Dependents.

- (e) In the case of (a)(1) above, COBRA continuation coverage may continue for up to 18 months. If, within the first sixty (60) days of continuation coverage, it is determined that the qualified beneficiary was disabled (under Title II or XV of the Social Security Act), continuation coverage may continue an additional 11 months, or a total of 29 months. To qualify for the additional 11 months, the Employer must be notified of the disability within 60 days after the date of determination. Such additional coverage will cease if the disability terminates. Therefore, the Employer must be notified within 30 days of the date of any final determination that the disability no longer exists. In the case of (a)(2) through (5), coverage may continue for up to 36 months. In the case of (a)(6), coverage may continue (1) until the death of the retired Participant or of any qualified beneficiary who, on the day before the qualifying event, was a surviving spouse of the Participant covered under the Plan, or (2) in the case of a surviving spouse or dependent child of the Participant, for up to 36 months after the death of the Participant. Notwithstanding the continuation periods specified above, COBRA continuation coverage shall terminate with respect to a qualified beneficiary upon the earlier of:
- (i) The date on which the Employer ceases to provide any group dental plan to any employee;
 - (ii) The date upon which coverage under the plan ceases as a result of failure to make timely premium payments as required by (f) below; premium payments shall be considered timely if made within 30 days of the due date; however, coverage shall be terminated retroactively as of the due date if payments are not received within 30 days; non-sufficient fund checks are not payment;
 - (iii) The date upon which the qualified beneficiary becomes covered under any other group dental plan (as an employee or otherwise) if such plan does not contain an exclusion or limitation with respect to any preexisting condition of such qualified beneficiary; or
 - (iv) The date upon which the qualified beneficiary (other than a qualified beneficiary described in (a)(6) above) becomes entitled to Medicare benefits.

In the event of multiple qualifying events, the maximum required continuation period is 36 months.

- (f) The Plan shall require payment of a premium for any period of COBRA continuation coverage in an amount that shall not exceed 102 percent of the cost to the Plan for such period of coverage for active Participants with respect to whom a qualifying event has not occurred. The cost to the Plan for coverage shall be determined for a period of 12 months selected by the Plan and shall be determined before the beginning of such period. The qualified beneficiary may elect to make any required premium payments in monthly installments. If the COBRA continuation period is extended from 18 months to 29 months due to disability as provided in (e) above, the premium for the additional 11 months of coverage shall be an amount not to exceed 150% of the cost to the Plan for such coverage, rather than 102% of such cost.
- (g) COBRA continuation coverage is not conditioned upon evidence of insurability.

Once continued coverage ends, it cannot be reinstated.

THIS EVIDENCE OF COVERAGE/SUMMARY PLAN DESCRIPTION CONSTITUTES ONLY A SUMMARY OF THE DENTAL PLAN. THE DENTAL PLAN CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.