YOUR BENEFITS

A Plan Designed to Provide Security for Employees of

County of Imperial

Dental Expense Coverage

Your benefit plan has been designed to provide financial help for you when a covered loss occurs. The plan is established through a Plan Document for the Planholder, County of Imperial.

The plan has been established on a noninsured basis; all liability for payment of benefits is assumed by the Planholder. While Principal Life Insurance Company administers payment of claims, Principal Life Insurance Company has no liability for the funding of the benefit plan.

While one of the functions of Principal Life Insurance Company is to process claims according to the plan provisions, all claims under the plan are paid by the Planholder and the Planholder owns the claim files. Therefore, the final decision on any disputed claim may involve review of these files by County of Imperial.

The Plan Administrator has complete discretion to construe or interpret all provisions, to determine eligibility for benefits, and to determine the type and extent of benefits, if any, to be provided. The Plan Administrator's decisions in such matters shall be controlling, binding, and final. In any action to review any such decision by the Plan Administrator, the Plan Administrator shall be deemed to have exercised its discretion properly unless it is duly proved that the Plan Administrator has acted arbitrarily and capriciously.

As a covered Member of the plan, your rights and benefits are determined by the provisions of the Plan Document. This booklet briefly describes those rights and benefits. It outlines what you must do to be covered. It explains how to file claims.

FUTURE OF PLAN. It is expected that this plan will be continued indefinitely. However, the Planholder does have the right to change or terminate the plan at any time.

PLEASE READ YOUR BOOKLET CAREFULLY. We suggest that you start with a review of the terms listed in the DEFINITIONS Section (at the back of the booklet). The meanings of these terms will help you understand the provisions of your plan.

The plan shall be construed and administered to comply in all respects with applicable federal law.

The Plan Administrator may from time to time enter into agreements, directly or indirectly, with health care providers or other third parties that would require the payment of benefits or the processing of claims and appeals in a manner other than as set forth in the plan. To the extent of any such inconsistency, the plan and summary plan description shall be deemed to be amended to conform to the requirements of those agreements.

Administered by:

PRINCIPAL LIFE
INSURANCE COMPANY
Des Moines, IA 50392-0002

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SUMMARY OF BENEFITS
(revised effective January 1, 2022)

This section highlights the benefits provided under your plan. The purpose is to give you quick access to the information you will most often want to review. Please read the other sections of this booklet for a more detailed explanation of your benefits and any limitations or restrictions that might apply.

DENTAL EXPENSE COVERAGE

If you or one of your Dependents receives dental Treatment or Service listed under the Schedule of Dental Procedures, Scheduled Benefits then in force will be payable. Scheduled benefits are based on your class and the status of your Dependents:

Class	Scheduled Benefits
All Members and their Dependents.....	All benefits for Covered Charges under Dental Care Units 1, 2, 3, and 4

Point of Service (POS) Plan

Your employer has agreed to participate in a Point of Service (POS) Plan identified by the Claims Administrator for this plan.

As you may know, Point of Service (POS) Plans are the most versatile type of plan and provide two to three tiers (points) of coverage. A person covered under a Point of Service (POS) plan can move between these different tiers of coverage each time dental care is received.

It is expected that your employer's participation in the POS Plan will result in significant savings of funds needed to maintain your plan. These savings are to be passed on to you in the form of higher plan benefits payable for services received by you or a Dependent from Exclusive Providers or Preferred Providers.

An Exclusive Provider or Preferred Provider directory is available by accessing Principal Life Insurance Company's website at www.principal.com or the EPO or PPO network's website. No matter how you access a directory, it is recommended that you (1) verify your provider's participation in the network before seeking treatment and (2) confirm EPO or PPO participation with your provider when making your appointment.

Please note that your employer's participation in the EPO or PPO does not mean that your choice of provider will be restricted. You may still seek needed dental care from any Dentist you wish. However, in order to avoid higher charges and reduced benefit payments, you are urged to obtain such care from Exclusive Providers or Preferred Providers whenever possible.

The Plan Administrator has the right to terminate the EPO or PPO portion of this plan. In the event of termination, benefits will be paid according to the level of benefits as described for dental care received from "Non-EPO/Non-PPO Providers."

Dental Care Units

The type of Treatment or Service covered under each of the Dental Care Units is:

Preventive Procedures ..... Unit 1
Basic Procedures..... Unit 2
Major Procedures ..... Unit 3
Orthodontia ..... Unit 4

DENTAL EXPENSE COVERAGE			
SERVICE	**EPO PROVIDER**	**PPO PROVIDER**	**NON-PPO/NON-EPO PROVIDERS**
Calendar Year Deductible*			
• Preventive Procedures	None	None	None
• Basic & Major Procedures combined			
Per Person	None	$25	$25
Per Family	None	$75	$75
• Orthodontia			
Per Person	None	None	None
Maximum Payment Limits*			
• **Preventive, Basic, & Major Procedures (combined)**	$2,000 per Calendar Year	$1,500 per Calendar Year	$1,000 per Calendar Year
• **Orthodontia**	$1,000 per lifetime	$1,000 per lifetime	$1,000 per lifetime
Procedure Categories			
• **Preventive**	100%	100%	100%
• **Basic**	100%	80%	80%
• **Major**	70%	50%	50%
• **Orthodontia**	50%	50%	50%
*PPO, EPO, Non-PPO, and Non-EPO Calendar Year Deductibles and Maximum Payment Limits reduce each other.			

Charges are applied to the Deductible Amount in the order in which they are incurred. However, if Covered Charges are incurred for Units 2 and 3 on the same date, the charges will be applied to the Deductible Amount in the following order:

- First, to Unit 2 charges; and
- Then, to Unit 3 charges.

In place of individual Deductibles, a family maximum Deductible may be applied. When this family maximum is satisfied for a Calendar Year, Dental benefits will be payable as if the individual Deductibles had been satisfied for each person in your family. For satisfaction of the family Deductible Amount, no more than one individual Deductible Amount will apply for any one person.

HOW TO BE COVERED - MEMBERS

DENTAL EXPENSE COVERAGE

Eligibility

To be eligible for coverage you must be a Member.

Member means any bargaining person who is:

- employed by the Planholder on other than a temporary basis; and
- regularly scheduled to work for the Planholder for at least 20 hours a week; and
- covered under the Planholder's group medical plan (Note: This provision is not applicable to individuals classified as retirees).

Member will also include any such person who is retired provided you participated in the plan prior to retirement and you have at least 10 years of service with the Planholder or retired from a county service connected with a disability under the terms and provisions of the 1937 Act and of Chapter 7 of the System's bylaws and regulations and the last service was with the County of Imperial.

You will be eligible on the first of the calendar month that next follows your date of hire.

Effective Date for Coverage

You must request initial coverage on a form provided by the Planholder. The requested coverage will become effective on:

- the date you are eligible, if the request is made on or before that date; or
- the first of the calendar month that next follows the date of your request, if you make your request within 31 days after the date you are eligible.

If request for coverage is made more than 31 days after the date an individual is eligible and other than during an Annual Open Enrollment Period or Special Enrollment Period described below, coverage for such individual will become effective as described below for Late Enrollees.

If request for coverage is made more than 31 days after the date an individual is eligible but during an Annual Open Enrollment Period described below, coverage for such individual will become effective as described below under "Annual Open Enrollment Period."

If request for coverage is made more than 31 days after the date an individual is eligible but during a Special Enrollment Period described below, coverage for such individual will become effective as described below under "Special Enrollment Periods."

Late Enrollment Provisions

- **Definition**

  - **Late Enrollee.** Late Enrollee means, with respect to coverage under an employer's group dental expense coverage, a Member or Dependent who enrolls under the plan other than during:
    - the first period in which the individual is eligible to enroll under the group dental expense coverage; or
    - a Special Enrollment Period described below.

For the purpose of the first item listed above, only the most recent period of eligibility will be considered in determining whether an individual is a Late Enrollee if:

- the individual loses eligibility under the group dental expense coverage due to termination of employment or due to a general suspension of the group dental expense coverage; and
- the individual later becomes eligible again under the group dental expense coverage due to resumption of employment or due to resumption of the group dental expense coverage.

The term "Late Enrollee" also means a Member or Dependent who:

- was previously covered under the Plan but elected to terminate the coverage; and
- reapplies for coverage more than 31 days after the termination date; and
- does not qualify for one of the Special Enrollment Periods described below.

- **Effective Date for Late Enrollees**

A Late Enrollee can only request coverage during an Annual Open Enrollment Period or Special Enrollment Period. Coverage for a Late Enrollee will become effective on the January 1st following the Annual Open Enrollment Period, provided on such date:

- the Member continues to meet the Plan's definition of a Member; and
- for Dependent coverage, the Dependents continue to meet the Plan's definition of Dependent.

- **Annual Open Enrollment Period**

An Annual Open Enrollment Period will be available for any Member or Dependent who failed to enroll:

- during the first period in which he or she was eligible to enroll, or during any subsequent Special Enrollment Period; or
- during any previous Annual Open Enrollment Period; or
- within 31 days after the termination date, if the individual was previously covered under the Plan but elected to terminate the coverage.

To qualify for enrollment during the Annual Open Enrollment Period, the Member or Dependent:

- must meet the eligibility requirements described in the Plan, including satisfaction of any applicable waiting period; and
- may not be covered under an alternate dental expense coverage offered by the employer, unless the Annual Open Enrollment Period happens to coincide with a separate open enrollment period established for coverage election.

The Annual Open Enrollment Period will be determined by the Planholder each year.

The effective date for any qualified individual requesting coverage during the Annual Open Enrollment Period will be each January 1st.

- **Special Enrollment Periods**

If you or your Dependent requests enrollment after the first period in which you or your Dependent was eligible to enroll but during a Special Enrollment Period as described below, you or your Dependent will be a Special Enrollee and will not be considered a Late Enrollee.

If the Planholder offers different benefit options, a benefit option transfer may also be made if your request is due to a Special Enrollment Period and you complete the appropriate enrollment form within the time specified for a Special Enrollment Period as described below. The effective date of the benefit option transfer will coincide with the effective date of your applicable Special Enrollment.

The Special Enrollment Periods are:

- Loss of Other Coverage: A Special Enrollment Period will apply to you or your Dependent if all of the following conditions are met:
  - You or your Dependent were covered under another group dental expense coverage at the time of initial eligibility, and declined enrollment solely due to the other coverage; and
  - The other coverage terminated due to loss of eligibility (including loss due to legal separation, divorce, death, cessation of Dependent status, termination of employment or reduction in work hours, incurring a claim that meets or exceeds the other coverage lifetime limit on all benefits, when the individual no longer resides, lives, or works in a service area and there is no other benefit package available under the other group dental expense coverage, or when the other group dental expense coverage no longer offers any benefits to a class of similarly situated individuals), or due to termination of employer contributions (or, if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation); and
  - Request for enrollment is made within 31 days after the other coverage terminates or after a claim is denied due to reaching the lifetime limit of all benefits under the other dental coverage.

  The effective date of coverage will be the first of the calendar month that next follows the date of the request for enrollment.

  NOTE: For the purpose of the second item listed above:
  - "Loss of eligibility" does not include a loss due to failure of the individual to pay contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the dental coverage); and
  - "Employer contributions" include contributions by any current or former employer (of the individual or another person) who was contributing to the coverage of the individual.

- Newly Acquired Dependents: A Special Enrollment Period will apply to you or your Dependent if:
  - You are enrolled (or are eligible to be enrolled but have failed to enroll during a previous enrollment period); and
  - A person becomes your Dependent through marriage, birth, adoption or Placement for Adoption; and
  - Request for enrollment is made within 31 days after the date of the marriage, birth, adoption, or Placement for Adoption.

The effective date of your or your Dependent's coverage will be:
- In the event of marriage, the date of the request for enrollment; or
- In the event of a Dependent child's birth, the date of such birth; or
- In the event of a Dependent child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption, whichever is earlier.

- Court-Ordered Coverage: A Special Enrollment Period will apply to your Dependent child if:
  - You are enrolled but have failed to enroll the Dependent child during a previous enrollment period; and
  - You are required by a court or administrative order to provide dental coverage for the Dependent child; and
  - Request for enrollment is made within 31 days after the issue date of the court or administrative order.

  The effective date of the Dependent child's coverage will be the first of the calendar month that next follows the date of the request for enrollment.

  A copy of the procedures governing qualified medical child support orders (QMCSO) can be obtained from the Plan Administrator without charge.

- Medicaid or Children's Health Insurance Program (CHIP): A Special Enrollment Period will apply to you and your Dependent if:
  - You or your Dependent is covered under a Medicaid or CHIP plan and coverage terminated as a result of loss of eligibility for Medicaid or CHIP coverage and your request for enrollment is made within 60 days after the date coverage is terminated; or
  - You become eligible for premium assistance under Medicaid or CHIP to purchase coverage under this plan and request for enrollment is made within 60 days after the date eligibility for premium assistance is determined.

  The effective date of coverage will be the first of the calendar month that next follows the date of the request for enrollment.

Effective Date for Benefit Changes – Change by Plan Amendment

A change in the amount of a Member's Scheduled Benefits because of a change in the Schedule of Coverage by amendment to this group plan will be effective on the date of change.

Termination

Unless continued as provided below or on pages 10, 15, and 17, your coverage will cease on the earliest of:
- the date the Group plan terminates; or
- the end of the calendar month for which the last contribution is made for your coverage; or
- the end of the calendar month in which you cease to belong to a class for which coverage is provided; or
- the end of the calendar month in which you cease to be a Member; or
- the end of the calendar month in which you cease to be actively employed.

Continuation

If you cease to be actively employed because of retirement, your Dental Expense Coverage may be continued until the date it would otherwise terminate as described above.

If you cease to be actively employed due to disability, leave of absence, temporary layoff, or termination, see the Planholder about possibly continuing group coverage.

In addition, by paying the required contribution, if any, your coverage may be continued under the continuation provisions described on pages 10, 15, and 17.

If you are interested in continuing your coverage beyond the date it would normally terminate, you should consult with the Planholder before your coverage terminates.

HOW TO BE COVERED - DEPENDENTS

DENTAL EXPENSE COVERAGE

Eligibility

You will be eligible for coverage for your Dependents on the later of:
- the date you are eligible for Member coverage; or
- the date you first acquire a Dependent.

Note: If both you and your spouse are Members under this plan, the individual considered most senior with the Planholder, will cover the other and any Dependent children that coverage is elected for.

Effective Date

Dependent coverage is available only with respect to Dependents of Members currently covered for Member coverage. If a Member is eligible for Dependent coverage, such coverage will become effective under the same terms as described earlier for Member coverage.

If Dependent coverage is then in effect for any other Dependent, a new Dependent will be covered on the date acquired. However, you must notify the Plan Administrator within 31 days after the date the Dependent is acquired. If such notice is not given to the Plan Administrator within the 31-day period, the Dependent will be subject to the Late Enrollment provisions. With respect to dental benefits for a newborn or newly adopted Dependent child, effective date provisions are modified as described below.

Coverage for a Newborn or Newly Adopted Child

A newly born or newly adopted Dependent child will be covered for dental benefits from the moment of birth, or on the date of adoption or Placement for Adoption (whichever is earlier), provided the child meets the definition of a Dependent child. Any applicable prior application or first of the calendar month provisions will be waived with respect to such child.

However, if you are required to contribute toward the cost of Dependent coverage, you must notify the Plan Administrator within 31 days after the date of birth, adoption, or Placement, in order to continue the child's coverage beyond the 31-day period. If such notice is not given to the Plan Administrator within the 31-day period, the child will be subject to the Late Enrollment provisions.

If the child's coverage terminates because you fail to request coverage (or pay the required contribution) within the 31-day period following the child's date of birth, adoption or Placement, benefits will be payable only for covered expenses incurred by the child during the 31-day period in which coverage was in force.

Termination

Unless continued as provided on pages 10, 15, and 17:

- Coverage for all of your Dependents will terminate on the earliest of:
  - the end of the calendar month for which the last contribution is made for your Dependent's coverage; or
  - the end of the calendar month in which you cease to belong to a class for which Dependent coverage is provided; or
  - the date Dependent coverage is removed from the Group plan; or
  - the date your Member coverage ceases.

- Coverage for any one Dependent will terminate on the last day of the calendar month in which he or she ceases to be your Dependent.

However, coverage will be continued beyond the maximum age for a Dependent child who is incapable of self-support because of a Developmental Disability or Physical Handicap and is dependent on you for primary support. You must apply for this continuation within 31 days after the child reaches the maximum age.

Continuation

In addition, under certain conditions, your Dependent's coverage may be continued after the date it would normally terminate. See the continuation provisions described on pages 10, 15, and 17.

COBRA CONTINUATION

Federal Required Continuation - Consolidated Omnibus Budget Reconciliation Act (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to any employer (except the federal government and religious organizations) that: (a) maintains a group health coverage; and (b) normally employed 20 or more employees on a typical business day during the preceding calendar year. For this purpose, "employee" means full-time employees and full-time equivalent for part-time employees.

Where applicable, COBRA requires that your group health coverage allow qualified persons (described below) to continue group health coverage after it would normally end. The term "group health coverage" includes any medical, dental, vision care, and prescription drug coverages that are part of your plan.

A. Qualified Persons/Qualifying Events

Continuation of group health coverage must be offered to the following persons if they would otherwise lose that coverage as a result of the following qualifying events:

(1) A Member (and any covered Dependents) following the Member's:
   (a) termination of employment for a reason other than gross misconduct; or
   (b) a reduction in work hours.
   (Note: Taking a family or medical leave under the Federal Family & Medical Leave Act (FMLA) is not a qualifying event under COBRA. A Member has a qualifying event when the Member does not return to work after the end of FMLA leave); and

(2) A Member's former spouse (and any Dependent children) following a divorce or legal separation from the Member; and

(3) A Member's surviving spouse (and any Dependent children), following the Member's death; and

(4) A Member's Dependent child following loss of status as a Dependent under the terms of the group plan (e.g., attaining the maximum age, marriage, joining the armed forces, etc.); and

(5) A Member's spouse (and any Dependent children) following the Member's entitlement to Medicare; and

(6) A Member's Dependent child who is born to or placed for adoption with the Member who is on COBRA continuation due to termination of employment or reduction in work hours; and

(7) If the group plan covers retired Members, a retired Member and his/her Dependents (or surviving Dependents) when retiree health benefits are "substantially eliminated" or terminated within one year before or after the employer files Chapter 11 (United States Code) bankruptcy proceedings.

Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Member elects to enroll.

B. Maximum Continuation Period

Following a qualifying event, health coverage can continue up to the maximum continuation period. The maximum continuation period for a Member (and any Dependents) following a termination of employment or reduction in work hours is 18 months from the date of the qualifying event. The maximum continuation period for a Member's Dependent child that is born to or placed for adoption with the Member while on COBRA continuation will extend to the end of the Member's maximum continuation period.

Following a termination of employment or reduction in work hours, a qualified person may request an 11-month extension of COBRA continuation. The maximum COBRA continuation will be 29 months from the date of the qualifying event (see Disabled Extension, Section D).

When a Member becomes entitled to Medicare before employment terminates or work hours are reduced, the maximum continuation period for the Dependents will be the longer of:

(1) 36 months dating back to the Member's entitlement to Medicare; or
(2) 18 months from the date of the qualifying event (termination of employment or reduction in work hours).

The maximum continuation period for qualified Dependents following a qualifying event described in A (2) through A (5) is 36 months from the date of the qualifying event.

If the group plan covers retired Members and the qualifying event is the employer's bankruptcy filing, the following rules apply:

(1) If the retired Member is alive on the date of the qualifying event, the retired Member and his or her spouse and Dependent children may continue coverage for the life of the retired Member. In addition, if the retired Member dies while covered under COBRA, the spouse or Dependent children may continue coverage for an additional 36 months.
(2) If the retired Member is not alive on the date of the qualifying event, his or her spouse may continue coverage to the date of his or her death.

C. Second Qualifying Events

If during an 18-month continuation period (or, 29 months for qualified persons on the disabled extension), a second qualifying event described in A (2) through A (5) occurs, the maximum continuation period may be extended for the qualified Dependents up to 36 months. That is, following a second qualifying event, qualified Dependents may continue for up to a maximum of 36 months dating from the Member's termination of employment or reduction in work hours. The extension is only available if the second qualifying event described in A (2) through A (5), absent the first qualifying event, results in a loss of coverage for Dependents under the group plan. A Member's Dependent child who is born to or placed for adoption with the Member who is on COBRA continuation may also be eligible for a second qualifying event that occurred prior to birth or placement for adoption.

D. Disabled Extension

Following a termination of employment or reduction in work hours, a qualified person (Member or Dependent) who has been determined disabled by the Social Security Administration either before or within 60 days after the qualifying event may request an extension of the continued coverage from 18 months to 29 months. A Member's Dependent child who is born to or placed for adoption with the Member who is on COBRA continuation must be determined disabled by the Social Security Administration within 60 days after the date of birth or placement for adoption. The disabled extension also applies to each qualified person (the disabled person and any family members) who is not disabled and who is on COBRA continuation as a result of termination of employment or reduction in work hours.

The 11-month extension for all qualified persons will end the earlier of (a) 30 days following the date the disabled person is no longer determined by Social Security to be disabled, or (b) the date continuation would normally end as outlined in Section E below.

E. Termination of Continued Coverage

Continued coverage ends the earliest of the following:

(1) The date the maximum continuation period ends; or

(2) The date the qualified person enrolls in Medicare. However, this does not apply to a person who is already enrolled in Medicare on the date he or she elects COBRA or to a person who is on COBRA due to the employer's bankruptcy filing as described in A (7); or

(3) The end of the last coverage period for which payment was made if payment is not made prior to the expiration of the grace period. (See Grace Period, Section I.); or

(4) The date the group plan is terminated (and not replaced by another group health plan); or

(5) The date the qualified person becomes covered by and has satisfied the preexisting exclusion provision of another group health plan, however, this does not apply to a person who is already covered by the other group health plan on the date he or she elects COBRA.

NOTE: Persons who, after the date of COBRA continuation election, become entitled to Medicare or become covered under another group health plan and have satisfied the preexisting exclusion provision, are not eligible for continued coverage. However, if the group plan covers retired Members, continued coverage for retired persons and their Dependents (or surviving Dependents) due to qualifying event A (7) above may not be terminated due to Medicare coverage.

F. Employer/Plan Administrator Notification Requirement

When a Member or Dependent has a qualifying event due to termination of employment, reduction in work hours, death of the Member, the Member entitlement to Medicare, or if the group plan covers retired Members, the commencement of the employer's Chapter 11 (United States Code) bankruptcy proceedings, the employer must notify the Plan Administrator within 30 days of the date of the qualifying event. The Plan Administrator must notify the qualified person of the right to COBRA continuation within 14 days after receiving notice of a qualifying event from the employer.

G. Qualified Person Notice and Election Requirements

Qualified persons must notify the Plan Administrator within 60 days after (a) the date of a qualifying event (i.e., divorce, legal separation, or a child ceases to be a Dependent child under the terms of the group plan) (b) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (c) the date the qualified person is first informed of this notice obligation; otherwise the right to COBRA continuation ends. This 60-day notice period applies to initial and second qualifying events.

Qualified persons who request an extension of COBRA due to disability must submit a written request to the Plan Administrator before the 18-month COBRA continuation period ends and within 60 days after the latest of the following dates: (a) the date of disability determination by the Social Security Administration; (b) the date of the qualifying event; (c) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (d) the date the qualified person is first informed of this notice obligation; otherwise the right to the disabled extension ends. Qualified persons must also notify the Plan Administrator within 30 days after the date the Social Security Administration determines the qualified person is no longer disabled.

Notification of a qualifying event to the Plan Administrator must include the following information: (a) name and identification number of the Member and each qualified beneficiary; (b) type and date of initial or second qualifying event; (c) if the notice is for an extension due to disability, a copy of any letters from the Social Security Administration and the Notice of Determination; and (d) the name, address and daytime phone number of the qualified person (or legal representative) that the Plan Administrator may contact if additional information is needed to determine COBRA rights.

Within 14 days after receiving notice of a qualified event from the qualified person, the Plan Administrator must provide the qualified person with an election notice.

Qualified persons must make written election within 60 days after the later of: (a) the date group health coverage would normally end; or (b) the date of the Plan Administrator's election notice. The election notice must be returned to the Plan Administrator within this 60-day period; otherwise the right to elect COBRA continuation ends.

Each qualified person has an independent right to elect COBRA. A covered Member may elect COBRA continuation on behalf of his/her covered spouse. A covered Member, parent, or legal guardian may elect COBRA continuation on behalf of his/her covered Dependent children.

To protect COBRA rights, the Plan Administrator must be informed of any address changes for covered Members and Dependents. Retain copies of any notices sent to the Plan Administrator.

H. Monthly Cost

Persons electing continued coverage can be required to pay 102% of the cost for the applicable coverage (COBRA permits the inclusion of a 2% billing fee). Persons who qualify for the disabled extension and are not part of the family unit that includes the disabled person can be required to continue to pay 102% of the cost for the applicable coverage during the disability extension. Persons who qualify for the disabled extension and are part of the family unit that includes the disabled person can be required to pay 148% of the cost for the applicable coverage (plus a 2% billing fee) for the 19th through the 29th month of coverage (or through the 36th month if a second qualifying event occurs during the disabled extension).

I. Grace Period

Qualified persons have 45 days after the initial election to remit the first contribution. The first contribution must include all contributions due when sent. All other contributions (except for the first contribution) will be timely if made within the Grace Period. "Grace Period" means the first 30-day period following a contribution due date. Except for the first contribution, a Grace Period of 30 days will be allowed for payment of contributions. Continued coverage will remain in effect during the Grace Period provided payment is made prior to the expiration of the Grace Period. If payment is not made prior to the expiration of the Grace Period, continued coverage will terminate at the end of the last coverage period for which payment was made.

J. Plan Changes

Continued coverage will be subject to the same benefits and rate changes as the group plan.

K. Newly Acquired Dependents

A qualified person may elect coverage for a Dependent acquired during COBRA continuation. All enrollment and notification requirements that apply to Dependents of active Members apply to Dependents acquired by qualified persons during COBRA continuation.

Coverage for a newly acquired Dependent will end on the same dates as described for qualified persons in Section B above. Exception: Coverage for newly acquired Dependents, other than the Member's Dependent child who is born to or placed for adoption with the Member, will not be extended as a result of a second qualifying event.

L. Contact Information

To notify the Plan Administrator of an initial or second qualifying event, request a disabled extension, request termination of COBRA, change of address, or request additional information concerning the group plan or COBRA, contact the following:

Benefits Coordinators Corporation (BCC)
Attn: Sherri Irvin
3838 Camino Del Rio Drive North
Ste 380
San Diego, CA 92108
Phone: (619) 624-9500, extension 320

FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)

Continuation

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects your group plan. See your employer for details on this continuation provision.

FMLA and Other Continuation Provisions

If your employer is an Eligible Employer and if the continuation portion of the FMLA applies to your coverage, these FMLA continuation provisions:

- are in addition to any other continuation provision of this plan, if any; and
- will run concurrently with any other continuation provisions of this plan for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

Eligible Employee

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and
- for at least 1,250 hours during the year preceding the start of the leave; and
- at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, “employs” has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- The birth of a child of an Eligible Employee and in order to care for the child;
- The placement of a child with the Eligible Employee for adoption or foster care;
- To care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a “serious health condition”;
- A “serious health condition” that makes the Eligible Employee unable to perform the functions of his or her job; or
- Because of a “qualifying exigency” arising out of a spouse, son, daughter or parent on active duty to a foreign country or having been notified of a call to active duty.

Eligible Employers are required to allow up to a total of 26 workweeks of unpaid leave during any 12-month period to eligible employees to care for a “covered military member” with a “serious injury or illness”. Covered military member means a current member of the Armed Forces and the National Guard or Reserves. It also includes a covered veteran who was a member of the Armed Forces (including a member of the National Guard or Reserves) and was discharged or released

under conditions other than dishonorable at any time during the five-year period prior to the first date an employee takes FMLA leave.

Eligible Employers are required to allow 15 days of unpaid leave during any 12-month period to eligible employees to spend time with a military member on “rest and recuperation” leave.

Reinstatement

An Eligible Employee’s terminated coverage may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

See your employer for details on this reinstatement provision.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Federal law requires that if your coverage would otherwise end because you enter into active military duty or inactive military duty for training, you may elect to continue coverage (including Dependents' coverage) in accordance with the provisions of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation

If active employment ends because you enter active military duty, coverage may be continued until the earliest of:

- for you and your Dependents:
  - the date the group plan is terminated; or
  - the end of the contribution period for which contributions are paid if you fail to make timely payment of a required contribution; or
  - the date 24 months after the date you enter active military duty; or
  - the date after the day on which you fail to return to active employment or apply for reemployment with the Planholder.

- for your Dependents:
  - the date Dependent Coverage would otherwise cease as provided on page 8; or
  - any date desired, if requested by you before that date.

The continuation provision will be in addition to any other continuation provisions described in this plan for sickness, injury, layoff, or approved leave of absence, if any. If you qualify for both state and USERRA continuation, the election of one means the rejection of the other.

Reinstatement

The reinstatement time period may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA.

This is a general summary of the USERRA and how it affects your group plan. See your employer for details on this continuation provision.

DESCRIPTION OF BENEFITS

DENTAL EXPENSE COVERAGE
(PAYMENT PROVISIONS)

Benefit Qualification

To qualify for payment of the benefits provided by your plan for a coverage class, you and your Dependents:

- must be covered in that class on the date dental Treatment or Service is received; and
- must satisfy the requirements listed in the CLAIM PROCEDURES Section.

Benefits Payable

Benefits payable will be as described in this section, subject to:

- all listed limitations; and
- the terms and conditions of COORDINATION WITH OTHER BENEFITS Section.

DENTAL EXPENSE COVERAGE

Payment Conditions

If you or one of your Dependents receives any Treatment or Service that is listed in the Schedule of Dental Procedures, the Planholder will pay Dental benefits for Covered Charges:

- in excess of the Deductible Amount(s); and
- at the payment percentage(s) indicated; and
- to the maximum allowances (indicated in the Schedule of Dental Procedures) and Maximum Payment Limits;

as described in the SUMMARY OF BENEFITS Section.

Covered Charges

Covered Charges will be the actual cost charged to you or your Dependent for Treatment or Service for the listed procedures shown in the SCHEDULE OF DENTAL PROCEDURES Section but only to the extent that the actual cost charged does not exceed Prevailing Charges. Also:

- If the Claims Administrator determines that more than one procedure could be performed to correct a dental condition, Covered Charges will be limited to the to the Prevailing Charge for the least expensive of the procedures that would provide professionally acceptable results.
- Covered Charges will include only those charges for Treatment or Service that begins (see below) while you and your Dependents are covered under this plan.
- Covered Charges will include only those charges for Treatment or Service that is completed while you and your Dependents are covered under the plan.

Beginning Date for Treatment or Service

Treatment or Service will be considered to begin:

- for root canal therapy, on the date the pulp chamber is opened and the pulp canal explored to the apex; and
- for crowns, fixed bridgework, inlays, or onlay restoration, on the date the tooth or teeth are fully prepared; and
- for complete or partial dentures, on the date the master impression is made; and
- for orthodontia, on the date the appliance or bands were first set; and
- for all other, on the date the Treatment or Service is performed.

Completion Date for Treatment or Service

Treatment or Service will be considered to be completed:

- for root canal therapy, on the date the tooth is sealed; and
- for crowns, on the date the crown is seated; and
- for fixed bridgework, on the date the bridge is seated; and
- for inlay or onlay restorations, on the date the inlay or onlay is seated; and
- for complete or partial dentures, on the date the complete or partial denture is seated.

DENTAL EXPENSE COVERAGE - LIMITATIONS

Limitations

Dental Covered Charges will not include and no benefits will be paid for:

- Treatment or Service that is not a Covered Charge; or
- any part of a charge for Treatment or Service that exceeds Prevailing Charges; or
- the services of any person who is not a Dentist or Dental Hygienist; or
- the services of any person in your Immediate Family or any person in your Dependent's Immediate Family; or
- veneers; anterior ¾ cast crowns, personalization of dentures or crowns (or any other Treatment or Service that is primarily cosmetic); or
- Treatment or Service that does not meet professionally recognized standards of quality; or
- drugs, medicines, or therapeutic drug injections; or
- instructions for plaque control, oral hygiene or diet; or
- bite registration or occlusal analysis; or
- Treatment or Service to alter or maintain vertical dimension or restore or maintain occlusion; or
- Treatment or Service to duplicate or replace a lost or stolen prosthetic device or to duplicate or replace a lost or stolen appliance. However, replacement of a lost or stolen crown, fixed bridge, or complete or partial denture will be considered a Covered Charge if such replacement meets the requirements as described in the SCHEDULE OF DENTAL PROCEDURES Section; or
- Treatment or Service for provisional or permanent splinting; or
- Orthodontic Treatment or Service if the appliance or bands were placed prior to being covered under this plan, unless you or your Dependent is currently in a treatment plan which was covered under prior group orthodontic coverage and there has been no Lapse in Coverage; or
- Treatment or Service for which you or your Dependent has no financial liability or that would be provided at no charge in the absence of coverage; or
- Treatment or Service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- implants; or
- Treatment or Service that results from war or act of war; or
- Treatment or Service that results from participation in criminal activities; or
- Treatment or Service that is covered by a Workers' Compensation Act or other similar law; or

- Treatment or Service that results from an injury arising from or in the course of any employment for wage or profit; except this limitation will not apply to: partners, proprietors, or corporate officers of the employer who are not covered by a Workers' Compensation Act or other similar law; or

- Treatment or Service paid for by a Medicare Supplement Insurance Plan; or

- Treatment or Service that is temporary; or

- Treatment or Service replacing tooth structure lost from abrasion, attrition, erosion or abfraction; or

- Treatment or Service which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years; or

- Treatment or Service for temporomandibular joint disorders; or

- charges by an anesthesiologist for services that were performed in facilities other than a dental office; or

- emergency room charges or outpatient facility charges (including but not limited to hospital outpatient facility charges); or

- Treatment or Service for patient management (including but not limited to nitrous oxide and analgesia), local anesthetic and general anesthesia and IV sedation, except as otherwise provided in the plan; or

- charges that are billed incorrectly or separately for Treatment or Services that are an integral part of another billed Treatment or Service as determined by the Claims Administrator; or

- Treatment or Service that is an Experimental or Investigational Measure; or

- Treatment or Service provided outside the United States except as follows:

    - for Treatment or Service provided in Mexico by providers participating in the FDH Mexico network. Benefits for such treatment will be paid at the same level as a PPO Provider; or

    - for Treatment or Service due to Emergency Treatment as defined.

SCHEDULE OF DENTAL PROCEDURES

Unless the Planholder agrees otherwise, Covered Charges will include only charges for procedures listed in the Schedule of Dental Procedures. If a non-listed procedure is accepted, the Planholder will determine its maximum allowance based on the Prevailing Charges for a listed procedure of comparable nature.

Dental Care Unit 1 - Preventive Procedures

If dental care is received from Exclusive Providers, Preferred Providers or from Non-EPO or Non-PPO Providers, the maximum allowance for each procedure described below will be the actual cost charged to you or your Dependent for Necessary Dental Care, but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Dental Procedure

Examinations

Only two of the below listed examinations will be covered in any Calendar Year.
- Oral examination (evaluation)
- Periodic examination (evaluation)
- Office visit

Limit combined with emergency examinations as described under Part 2 – Basic Procedures.

Second Opinion

Benefits will be payable for a Second Opinion obtained with respect to a recommended Treatment or Service at 100% of Second Opinion Consultation Charges, subject to Prevailing Charges.

Note: Obtaining a confirming Second Opinion does not guarantee payment of the Treatment or Service. All other terms, provisions, conditions, limitations, and exclusions of the plan remain in full force and effect with respect to benefits.

Radiographs

Full Mouth Survey
- Complete series (including bitewings)
- Panoramic

Only one of the listed full mouth surveys will be covered in any 60 consecutive months.

Bitewing
- Limited to a maximum of 4 bitewing films in one visit, twice in any Calendar Year.

Occlusal
- Only two films will be covered in any Calendar Year.

Periapical
- Only four films will be covered in any Calendar Year.

Extraoral x-rays
- Sialography
- Cephalometric film
- Posterior-anterior or lateral skull and facial bone survey
- Other extraoral

Only two of the listed extraoral procedures will be covered in any 12 consecutive month period.

Diagnostic x-rays performed in conjunction with root canal therapy or orthodontic treatment will not be considered Unit 1 Covered Charges.

Preventive Services

Prophylaxis (cleaning of teeth)

Limited to two dental prophylaxis (routine cleaning or periodontal cleaning/maintenance procedure) in any Calendar Year. Both routine cleaning and periodontal cleaning (maintenance procedure) will apply towards the two per Calendar Year frequency limit.

Topical application of fluoride

Applicable only to Dependent children under age 18. Only one application will be covered in any Calendar Year.

Topical application of sealants

Applicable only to first and second permanent molars for Dependent children under age 18. Covered once each tooth in any 36 consecutive month period.

Other Services

Harmful Habit Appliance

Limited to one time per person under the age of 18.

Space maintainers

Applicable only to Dependent children under age 18. Repairs to space maintainers are not covered. Limited to one bilateral space maintainer per arch or one unilateral space maintainer per quadrant.

Dental Care Unit 2 - Basic Procedures

If dental care is received from Exclusive Providers, Preferred Providers or from Non-EPO or Non-PPO Providers, Covered Charges will be the actual cost charged to you or your Dependent for Treatment or Service for the listed procedures described in this section, but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Dental Procedure

Restorations

Fillings (amalgam or resin-based composite)

Anterior

Mesial-lingual, distal-lingual, mesial-buccal, and distal buccal restorations will be considered single surface restorations.

Multiple restorations on adjacent surfaces of the same tooth are considered connected. Benefits will be based on the benefit for a single restoration reflecting the number of different surfaces.

Multiple restorations on the same surface of the same tooth will be based on the benefit for a single surface restoration.

Posterior

Multiple restorations on adjacent surfaces of the same tooth are considered connected. Benefits will be based on the benefit for a single restoration reflecting the number of different surfaces.

Multiple restorations on the same surface of the same tooth will be based on the benefit for a single surface restoration.

Replacement

Replacement of existing fillings are covered only if at least 24 consecutive months have passed since placement of prior fillings, unless required by new decay in an additional tooth surface.

Benefits for composite restorations on posterior teeth will be based on the benefits for the corresponding amalgam restorations.

Stainless steel crown
Prefabricated resin crown

For Dependent children under the age of 19, only one of the listed crowns will be covered in any 24 consecutive month period. If a stainless steel or prefabricated resin crown is used for an adult in lieu of a permanent crown, all replacement restrictions will be as listed for permanent crowns on GH 1111. If a permanent crown replaces a crown listed in this section at a later date but before replacement restrictions allow, all new charges will be reduced by those already paid.

Endodontic Services

Vital pulpotomy

Covered for deciduous teeth only

Root canal therapy including treatment plan, intra-operative x-rays, clinical procedures, and follow-up care

Retreatment of previous root canal therapy is covered once per tooth per lifetime.

Apexification
Apicoectomy (Covered once per root per lifetime)
Retrograde filling (Covered once per root per lifetime)
Root amputation
Root resection
Hemisection

Periodontic Services

Scaling and root planing (each quadrant)
Covered once each quadrant in any 24 consecutive month period.

Note: If you or your Dependent is pregnant, diabetic, or has heart disease, scaling and root planning will be paid at 100% and one additional routine cleaning or periodontal cleaning will be allowed.

Full Mouth Debridement
Covered once per lifetime. Only covered if no other service (other than x-rays) is provided during the visit.

Periodontal prophylaxis (including probing, charting, exam, polishing, scaling, root planing and similar maintenance procedures).
Covered only if at least three months have elapsed after completion of covered active therapeutic scaling and root planing or covered active surgical periodontal treatment. Limited to two dental prophylaxis (routine cleaning or periodontal cleaning/maintenance procedure) in any Calendar Year. Both routine cleaning and periodontal cleaning (maintenance procedure) will apply towards the two per Calendar Year frequency limit.

Periodontal Surgical Procedures

Gingival flap procedure
Gingivectomy
Osseous surgery
Pedicle soft tissue graft
Free soft tissue graft
Subepithelial connective tissue graft
Distal or proximal wedge procedure
Crown lengthening

Only one of the listed periodontic surgical procedures is covered for each quadrant in any 36 consecutive months.

Bone Replacement Graft
Covered once per site per lifetime.

Oral Surgery

Simple extraction
Surgical removal of erupted tooth
Root removal – exposed roots
There will be no separate benefit payable for bone grafting of an extraction site

Incision and drainage of dental abscess

Biopsy of soft tissue

Other Oral Surgical Procedures

Extraction of impacted teeth (soft tissue, partial bony, complete bony)
Surgical root removal
There will be no separate benefit payable for bone grafting of an extraction site.

Alveoplasty
Removal of exostosis
Removal of palatal torus
Removal of mandibular tori
Frenectomy
Transseptal fiberotomy
Excision of hyperplastic tissue
Surgical exposure of impacted or unerupted tooth
Vestibuloplasty
Removal of dental cysts and tumors

Anesthesia

General anesthesia
IV Sedation
General anesthesia or IV sedation is payable for the following covered services when performed in the dental office. Benefits for anesthesia is limited to one hour unless complexity of service warrants extended time.

Removal of impacted teeth, removal of dental cysts and tumors, multiple restorative services for Dependent children under the age of 5, periodontal osseous surgery, bone grafting, surgical removal of four third molars on the same date of service.

Other Services

Emergency Exam
Covered as a separate procedure only if no other service (except x-rays) is provided during the visit. Only two exams are covered in any Calendar Year. Limit combined with routine examinations limit under Part 1 – Preventive Procedures.

Consultation with specialist
Covered once in any 12 consecutive months. Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Antibiotic drug injection

Office visit after regularly scheduled hours
Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Palliative treatment
Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Occlusal Guard (except for treatment of TMJ)
Limited to one guard per 36 months or if necessary to replace due to the placement of bridgework or three or more posterior crowns after the placement of the guard.

Dental Care Unit 3 - Major Procedures

If dental care is received from Exclusive Providers, Preferred Providers or from Non-EPO or Non-PPO Providers, Covered Charges will be the actual cost charged to you or your Dependent for Treatment or Service for the listed procedures described in this section, but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Dental Procedure

Restorations

Inlays and onlays

Inlay or onlay restorations are covered only if the tooth cannot be restored by a filling and (for replacements) at least 60 consecutive months have elapsed since the last placement. For persons under 16 years of age, the benefit for inlay is limited to amalgam or resin filling. For persons under 16 years of age, the benefit for onlay is limited to resin or stainless steel crowns.

The date the inlay or onlay is cemented in the mouth will be used in determining benefits payable.

Crowns (single restorations only)

Resin (laboratory)
Resin with nonprecious metal
Resin with semiprecious metal
Resin with gold
Porcelain
Porcelain with nonprecious metal
Porcelain with semiprecious metal
Porcelain with gold
Porcelain (3/4 posterior cast)
Gold (3/4 posterior cast)
Gold (full cast)
Nonprecious metal (full cast)
Semiprecious metal (full cast)

Crowns are covered only if the tooth cannot be restored by a filling and (for replacements) at least 60 consecutive months have elapsed since the last placement. Crowns for the primary purpose of splinting, altering, or maintaining vertical dimension, or restoring occlusion are not covered. Crowns for the replacement of inlay, onlay, or bridge abutment are covered only if at least 60 consecutive months have elapsed since the last placement of the restoration. Crowning of implant replacing a tooth missing prior to the effective date is not covered. For persons under 16 years of age, the benefit for crowns on vital teeth is limited to resin or stainless steel crowns. Crowning of implant replacing a pontic will not be covered unless at least 60 consecutive months have elapsed since placement of the pontic. The date the crown is cemented in the mouth will be used in determining benefits payable.

Cast post and core

Covered only for teeth that have had root canal therapy. Covered once per tooth per 60 consecutive months. There will be no separate benefit payable for cast post and core if restorative procedure is not covered under this plan.

Core Buildup

Covered only when required for retention and preservation of the tooth. There will be no separate benefit payable for core buildup if restorative procedure is not covered under this plan.

Covered once per tooth per 60 consecutive month period.

Prosthodontics, Fixed

Fixed bridges - initial placement or replacement

Coverage for bridges limited to persons over age 16.

Initial placement of fixed bridges to replace teeth which were missing prior to the effective date of the individual's coverage will not be covered unless it includes the replacement of a Functioning Natural Tooth extracted while the person is covered under this plan (provided that tooth was not an abutment to an existing partial denture that is less than 60 months old). In that event, benefits are payable only for the replacement of those teeth which were extracted while covered under the plan.

Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than 60 consecutive months old. The date bridgework is cemented in the mouth will be used in determining benefits payable.

Prosthodontics, Removable

Complete or partial dentures - initial placement or replacement

Initial placement of complete or partial dentures to replace teeth which were missing prior to the effective date of the individual's coverage will not be covered unless it includes the replacement of a Functioning Natural Tooth extracted while covered under this plan. In that event, benefits are payable only for the replacement of those teeth which were extracted while covered under the plan.

Benefits for the replacement of an existing complete or partial denture are payable only if the existing denture is more than 60 consecutive months old.

Covered Charges for complete or partial dentures do not include any additional charges for over-dentures or for precision or semi-precision attachments.

Other Services

Recementing
Inlay
Onlay
Crown
Bridgework
Covered only if done more than 12 months after initial insertion of inlay, onlay, crown, or bridge, and then not more than one time in any 24 consecutive month period.

Repairs to complete or partial denture, bridge, or crown
Covered only if repair is done more than 12 months after initial insertion of the denture, bridge, or crown, and then not more than one time in any 24 consecutive month period.

Relining or rebasing complete or partial dentures
Covered only if relining or rebasing is done more than 12 months after initial insertion of the denture and then not more than one time in any 24 consecutive month period.

Tissue conditioning
Covered only if at least 12 months have elapsed since the insertion of a complete or partial denture and not more than once in any 24 consecutive month period.

Denture adjustment

Covered once in any 12 consecutive month period and then only if at least 12 months have elapsed since the insertion of the denture.

Dental Care Unit 4 - Orthodontia

If dental care is received from Exclusive Providers, Preferred Providers or from Non-EPO or Non-PPO Providers, Covered Charges will be the actual cost charged to you or your Dependent for Treatment or Service for the listed procedures described in this section, but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Orthodontic Services

Formal, full-banded retention and treatment, including x-rays and other diagnostic procedures.

Removable or fixed appliances for tooth or bony structure guidance or retention.

COORDINATION WITH OTHER BENEFITS

DENTAL EXPENSE COVERAGE

Applicability

These Coordination of Other Benefits (COB) provisions apply to this Plan when you or one of your Dependents have dental care coverage under more than one Plan. "Plan" is defined below.

If the COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this Plan are determined before or after those of another plan. The benefits of this Plan:

- will not be reduced when, under the order of benefit determination rules, this Plan determines its benefits before another plan; but

- may be reduced when, under the order of benefits determination rules, another plan determines its benefits first.

Benefits paid under all other Plans plus the sum of benefits paid under This Plan will not exceed the lesser of the financial liability of the Member or Dependent or our Prevailing Charge for a Treatment or Service.

Definitions

“Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment.

- any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or association; and

- any program required or established by state or Federal law (including Medicare Parts A and B); and

- any program sponsored by or arranged through a school or other educational agency; and

- the first-party medical expense provisions of any automobile policy issued under a no-fault insurance statute and traditional fault-type contracts.

The term Plan will not include benefits provided under a student accident policy, nor will the term Plan include benefits provided under a state medical assistance program where eligibility is based on financial need.

Primary Plan/Secondary Plan: The order of benefit determination rules determine whether this Plan is a “Primary Plan” or a “Secondary Plan” when compared to another Plan covering the person.

When this Plan is Primary, its benefits are determined before those of any other Plan and without considering any other Plan’s benefits. When this Plan is Secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan’s benefits.

Allowable Expense: A dental care service or expense, including Deductibles, coinsurance, and Copayments, if any, that is covered at least in part by any of the Plans covering the person for whom benefits are claimed. When a Plan provides benefits in the form of services (for example an

DHMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. The following are examples of expenses or services that are not allowable expenses:

- If a person is covered by two or more Plans that compute their benefits payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

- The amount a benefit is reduced by the Primary Plan because a covered person does not comply with the Plan provisions. Example of this provision is preferred provider arrangements.

"Claim Determination Period" means the part of a Calendar Year during which you or a Dependent would receive benefit payments under this Plan if this section were not in force.

Effect on Benefits

Benefits otherwise payable under this Plan for Allowable Expenses during a Claim Determination Period may be reduced if:

- benefits are payable under any other Plan for the same Allowable Expenses; and

- the rules listed below provide that benefits payable under the other Plan are to be determined before the benefits payable under this Plan.

The reduction will be the amount needed to provide that the sum of payments under this Plan plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses.

For this purpose:

- benefits payable under other Plans will include the benefits that would have been paid had claim been made for them;

- for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B whether or not the person is covered under that Part B.

Order of Benefit Determination

General. Except as described below under Medicare Exception, the benefits payable of a Plan that does not have a coordination of benefits provision similar to the provision described in this section will be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination will be:

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

- **Non-Dependent/Dependent.** The plan which covers the person as an employee, member, or subscriber (that is, other than as a Dependent) is determined before those of the plan which covers the person as a Dependent. Exception: If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

  - Secondary to the Plan covering the person as a Dependent and

  - Primary to the Plan covering the person as other than a Dependent (e.g. a retired employee), then the benefits of the Plan covering the person as a Dependent are determined before those of the Plan covering that person as other than a Dependent.

- **Dependent Child--Parents Not Separated or Divorced.** If a Dependent child is covered by both parents' Plans, the Plan of the parent whose birthday falls earlier in the Calendar Year will be determined before those of the Plan of the parent whose birthday falls later in that year. But, if both parents have the same birthday or if the other Plan does not have a birthday rule, and as a result the Plans do not agree on the order of benefits, the benefits of the Plan which covered a parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

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

- **Dependent Child--Separated or Divorced Parents.** If a Dependent child of legally separated or divorced parents is covered under two or more Plans, benefits for the Dependent child are determined in this order:

  - first, the Plan of the parent with custody of the Dependent child;

  - then, the Plan of the spouse of the parent with custody of the Dependent child; and

  - finally, the Plan of the parent not having custody of the Dependent child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the Dependent child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply for any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- **Joint Custody.** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Dependent child, the Plans covering the Dependent child shall follow the order of benefit determination rules for Dependent children of parents who are not separated or divorced.

- **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid-off nor retired are determined before those of a Plan which covers that person as a laid-off or retired employee. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- **Continuation of Coverage.** If a person for whom coverage is provided under a right of continuation according to Federal or state law is also covered under another Plan, the following will be the order of benefit determination:

  - first, the benefits of a Plan covering the person as an employee, Member or subscriber (or as that person's Dependent);

  - second, the benefits under the continuation coverage.

  If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- **Longer/Shorter Length of Coverage.** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an employee, Member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

Medicare Exception

Unless otherwise required by Federal law, benefits payable under Medicare will be determined before the benefits payable under the This Plan. Federal law will usually apply in such instances if:

- the benefits are applicable to an active (rather than a retired) Member or to that Member's spouse; and

- the Member's employer has 20 or more employees.

How COB Works

Example 1: The natural father is covered as a Member under this Plan. Company A covers the natural mother. Company B covers the stepfather. The natural mother has custody of the Dependent child and the divorce decree does not establish financial responsibility for medical, dental, or other health care expenses.

The following order of benefits would apply to the Dependent child:

1. Company A would be Primary (mother's carrier).

2. Company B would be Secondary (stepfather's carrier).

3. We would then determine the benefits payable, if any, under this Plan.

Example 2A: Mrs. Smith has filed a claim for $600 with both Company A and Company B. Company A covers Mrs. Smith as an employee under a plan which pays 80% of Covered Charges after a $50 Calendar Year deductible is satisfied. Company B covers her as a dependent spouse under a plan.

Both plans have a COB provision, therefore, Company A would pay first since it covers Mrs. Smith as an employee. Since Company A pays first, it calculates benefits in full as though duplicate coverage did not exist.

Company A

Billed Charges	$	600.00	
Not Covered by Primary Carrier	$	-20.00	(oral hygiene instructions)
Total Covered Charges	$	580.00	
Less Deductible	$	-50.00	
Benefits Payable ($530 X 80% = $424)	$	424.00	

Once Company A has determined and paid its benefits, Mrs. Smith's claim is then considered by Company B. In calculating its benefit, Company B must include any expenses that would be allowable expenses under the Company A plan.

Company B

Allowable Expenses	$	580.00
Less Company A Benefits	$	-424.00

Benefits Payable	$ 156.00	

The Patient is responsible for $20 which is not considered a covered expense under either plan.

Example 2B: The same rules apply in this example as they did in Example 2A. Mrs. Smith has filed an additional claim for $800 with both Company A and Company B. Company A covers Mrs. Smith as an employee under a plan which pays 80% of Covered Charges after a $50 Calendar Year deductible is satisfied. Company B covers her as a dependent spouse under a plan.

Both plans have a COB provision, therefore, Company A would pay first since it covers Mrs. Smith as an employee. Since Company A pays first, it calculates benefits according to their plan's Covered Charges as though duplicate coverage did not exist.

Company A

Billed Charges	$ 800.00	
Not Covered by Primary Carrier	$ -20.00	(oral hygiene instructions)
Total Covered Charges	$ 780.00	
Less Deductible	$ -50.00	
Benefits Payable ($730.00 X 80% = $584)	$ 584.00	

Once Company A has determined and paid its benefits, Mrs. Smith's claim is then considered by Company B. In calculating its benefit, Company B must include any expenses that would be allowable expenses under the Company A plan.

Company B

Allowable Expenses	$ 780.00
Less Company A Benefits	$ -584.00
Benefits Payable by Company B	$ 196.00

The Patient is responsible for $20 which is not considered a covered expense under either plan.

CLAIM PROCEDURES

Claim Forms

Except in the case of dental care received from Exclusive Providers or Preferred Providers, claim forms and other information needed to prove loss must be filed with the Plan Administrator in order to obtain payment of plan benefits. The Planholder will provide forms and other filing assistance. If forms are not provided within 15 calendar days after the Planholder receives such notice of claim, you will be considered to have complied with the requirements of the group plan regarding proof of loss upon submitting, within the time specified below for filing proof of loss, written proof covering the occurrence, character, and extent of the loss.

When you become covered, you will be issued an identification card. This card should be presented to each provider at the time you or a Dependent receives needed dental care.

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to the Claims Administrator within 90 calendar days but no later than 12 months after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when we receive proof of loss. Proof of loss includes the patient's name, your name (if different from patient's name), provider of services, dates of service, diagnosis, description of Treatment or Service provided, and extent of the loss. The Claims Administrator may request additional information to substantiate your loss or require a signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim. The Claims Administrator may also require x-rays, dental charts, and other evidence needed to determine the dental condition treated and the services provided.

Payment, Denial, and Review

The plan permits up to 30 calendar days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, the Claims Administrator will either deny the claim or send a written explanation prior to the expiration of the 30 calendar days. If the Claim Administrator does not deny the claim and requests additional information to complete the review, the Claimant is then allowed up to 45 calendar days to provide all additional information requested. The Claims Administrator will render a decision within 15 calendar days of either receiving the necessary information or upon expiration of 45 calendar days if no additional information is received.

In actual practice, benefits under the group plan may be processed and paid within a few days after the Claims Administrator receives completed proof of loss. If a claim cannot be paid, the Claims Administrator will promptly explain why.

A Claimant may request an appeal of a claim denial by written request to the Claims Administrator within 180 calendar days of receipt of notice of the denial. The Claims Administrator will make a full and fair review of the claim. The Claims Administrator may require additional information to make the review. The Claims Administrator will notify the claimant in writing of the appeal decision within 60 calendar days of receiving the appeal request. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

For purposes of this section, "Claimant" means you or your Dependent.

Preferred or Exclusive Providers

When you become covered, you will be issued an identification card. This card should be

presented to each PPO or EPO Provider at the time you or a Dependent receive needed dental care. Each PPO or EPO Provider will provide you with a claim form and other filing assistance.

Dental Treatment Plan

The use of predeterminations to determine the extent of coverage for a proposed course of treatment is encouraged. A Dental Treatment Plan may be filed with the Claims Administrator before treatment begins. Upon receipt of the Dental Treatment Plan, the Claims Administrator will provide a written response indicating the benefits that may be payable for the proposed treatment. Predetermination of benefits for the following non-emergency types of treatments: inlays, onlays, single crowns, prosthetics, periodontics and oral surgery is suggested.

The filing of a Dental Treatment Plan is intended to help avoid any misunderstanding between you, the Dentist, and the Plan Administrator as to how much will be paid for dental work. A Dental Treatment Plan is not a guarantee of what the Plan Administrator will pay. It informs you and the Dentist in advance what the Plan Administrator will pay for a covered dental service named in the Dental Treatment Plan. Payment is subject to the Benefit Qualifications as shown on page 18 of this booklet. If the Plan Administrator does not agree with a Dental Treatment Plan, or if one is not sent in, the Plan Administrator has the right to base payments on treatment suited to your condition by accepted standards of dental practice.

Facility of Payment

The Planholder will normally pay all benefits (for other than orthodontia) to you. However, if the claimed benefits result from a Dependent's sickness or injury, the Planholder may make payment to the Dependent. Orthodontia benefits will be payable as described below. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge the Planholder to the full extent of those payments.

- If payment amounts remain due upon your death, those amounts may, at the Planholder's option, be paid to your estate, spouse, child, parent, or provider of dental services.
- If the Planholder believes a person is not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, the Planholder may pay whoever has assumed the care and support of the person.
- Benefits payable to an Exclusive Provider or Preferred Provider will be paid directly to the Exclusive Provider or Preferred Provider on behalf of you or a Dependent.

Payment of Orthodontia Benefits

Benefits under the plan for comprehensive orthodontia treatment will be payable in installments.

The Planholder will pay orthodontia benefits:

- immediately upon receipt of proof that the initial treatment (including setting of the appliance or bands) has been completed; and
- at the end of each following calendar month upon receipt of proof that the Period of Dental Treatment has continued.

The Covered Charge for the initial treatment will be 25% of the lesser of:

- the Dental Care Unit 4 lifetime maximum payment limit; or
- Covered Charges as outlined on page 30, multiplied by the coinsurance shown on page 1 for Dental Care Unit 4.

The monthly Covered Charge will be determined by averaging the remaining Covered Charge over the estimated time required to complete the Orthodontic Treatment or Service.

Treatment or Service for other than comprehensive orthodontia treatment may be paid in one lump sum.

The Dental Care Unit 4 Maximum Payment Limit under the group plan will be reduced by any orthodontia benefits paid under the Prior Plan.

For the purposes of this section, "Prior Plan" will mean the Member's group dental expense coverage for which the group plan is a replacement.

Orthodontia Treatment or Service will not be covered if the appliance or bands were placed prior to being covered under the group plan, unless:

- you or your Dependent is currently in a treatment plan which was covered under the Prior Plan; and
- there has been no Lapse in Coverage; and
- you or your Dependent submits proof that:
  - the Dental Care Unit 4 Maximum Payment Limit under this group plan was not exceeded under the Prior Plan; and
  - the orthodontic treatment was started and bands or appliances were inserted while covered under the Prior Plan; and
  - orthodontic treatment has been continued while you or your Dependent is covered under the group plan.

Recoding of Procedures

When a claim contains one or more procedure codes with the same date of service, the Claims Administrator may review the claim to determine whether it contains, among other things, coding irregularities (including duplicative or combined codes), coding conflicts or coding errors. Such review will be based on generally recognized and authoritative coding resources, including but not limited to: Current Dental Terminology (CDT).

If the Claims Administrator determines that the claim may be more appropriately coded using the same or different codes, the claim will be recoded and processed accordingly to determine the allowable amount and extent of benefits.

Dental Examinations

The Planholder may have the person whose loss is the basis for dental claim examined by a Dentist. The Planholder will pay for these examinations and will choose the Dentist to perform them.

Legal Action

Legal action for a claim may not be started earlier than 90 calendar days after proof of loss is filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after proof is required to be filed.

Time Limits

All time limits listed in this section will be adjusted as required by law.

Right of Recovery

If it is determined that benefits paid under the plan document are in excess of benefits that should have been paid, the Planholder will have the right to recover those payments from the person to or for whom the benefits were paid.

DEFINITIONS

Several words and phrases used to describe your plan are capitalized whenever they are used in this booklet. These words and phrases have special meanings as explained in this section.

Calendar Year means January 1 through December 31 of each year.

Claims Administrator means any entity authorized by the Plan Administrator to process claims for benefits under this plan.

Covered Charges means a Treatment or Service is considered to be a Covered Charge if the Treatment or Service is prescribed by a Dentist and is determined by the Claims Administrator to be:

- necessary and appropriate;
- Generally Accepted.

Deductible; Deductible Amount means a specified dollar amount of Covered Charges that must be incurred by you or one of your Dependents before benefits will be payable under this plan for all or part of the remaining Covered Charges during the Calendar Year.

Dental Hygienist means a person who works under the supervision of a Dentist and is licensed to practice dental hygiene.

Dental Treatment Plan means the Dentist's report of proposed treatment which:
- is in writing; and
- lists the procedures required for the Period of Dental Treatment; and
- shows the charges for each procedure; and
- is accompanied by any diagnostic materials that the Claims Administrator might require.

Dentist means:
- a person licensed to practice dentistry; and
- a licensed Physician who provides dental Treatment or Service.

Dependent means:

- Your legally married spouse, if your spouse:
  - is not in the Armed Forces of any country; and
  - is not covered under this plan as a Member.

- Your Domestic Partner, if your Domestic Partner:
  - is not in the Armed Forces of any country; and
  - is not covered under this plan as a Member; and
  - and you complete and submit a Declaration of Domestic Partnership with the California Secretary of State.

- Your natural, legally adopted children, stepchildren, or any child for which you are a non-temporary legal guardian by a court of appropriate legal jurisdiction, if your child:
  - is not in the Armed Forces of any country; and
  - is not covered under this plan as a Member; and
  - receives principal support from you; and
  - is approved in writing by the Plan Administrator as a Dependent child; and
  - is less than 26 years of age.

  A newly adopted child will be considered a Dependent child from the date of Placement with you for the purpose of adoption or the date of adoption, whichever is earlier. The

child will continue to be a Dependent child unless the Placement is disrupted prior to legal adoption and the child is removed from Placement.

Dependent will include a Domestic Partner's child(ren) provided they meet the requirements described previously.

Dependent will also include any child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to this plan, provided the child meets this plan's definition of a Dependent.

Dependent does not include foster children.

Dependent does include a common law spouse as defined by the state in which you reside.

Developmental Disability means a Dependent child's substantial handicap, as determined by the Plan Administrator, which:

- results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and
- is diagnosed by a Physician as a permanent or long-term continuing condition.

Domestic Partner means an individual who is personally related to the Member by a domestic partnership that meets the following requirements:

- domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring; and
- both persons have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex domestic partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age.

The domestic partnership is deemed crated on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

Emergency Treatment means any Necessary Dental Care which is rendered as the direct result of an unforeseen occurrence or combination of circumstances which requires immediate, urgent action or remedy.

Exclusive Provider/EPO Provider means a Dentist who has agreed to participate in the Dental Exclusive Provider Organization (PPO) network identified by the Claims Administrator for this plan.

Experimental or Investigational Measures mean any Treatment or Service, regardless of any claimed therapeutic value, not Generally Accepted by specialists in that particular field of medicine or dentistry, as determined by the Plan Administrator or its delegate.

Functioning Natural Tooth means a Natural Tooth which is performing its normal role in the chewing process in the covered person's upper or lower arch and which is opposed in the person's other arch by another Natural Tooth or prosthetic (i.e. artificial) replacement.

Generally Accepted means the Treatment or Service for the particular sickness or injury which is the subject of the claim that:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature; and
- is in general use in the relevant dental community; and
- is not under scientific testing or research.

Harmful Habit Appliances means appliances, either fixed or removable, used to train or remind a patient to avoid thumb sucking or tongue thrusting (does not include treatment for bruxism – clenching or grinding of the teeth).

Immediate Family means a covered person's spouse, natural or adoptive parent, child or sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or spouse of grandparent or grandchild.

Lapse in Coverage means any break in coverage during which a person is not covered under another group dental expense coverage, including but not limited to, any Planholder benefit waiting period. Continuation provided under COBRA or any state required continuation will not be considered a break in coverage.

Member means any bargaining person who is:

- employed by the Planholder on other than a temporary basis; and
- regularly scheduled to work for the Planholder for at least 20 hours a week; and
- covered under the Planholder's group medical plan (Note: Not applicable to individuals classified as retirees).

Member will also include any such person who is retired provided you participated in the plan prior to retirement and you have at least 10 years of service with the Planholder or retired from a county service connected with a disability under the terms and provisions of the 1937 Act and of Chapter 7 of the System's bylaws and regulations and the last service was with the County of Imperial.

Natural Tooth means any tooth or part of a tooth that is organic and formed by the natural development of the body (i.e. not manufactured).

Necessary Dental Care means any Treatment or Service prescribed by a Dentist and determined by the Plan Administrator or its delegate to be:

- necessary and appropriate; and
- not Experimental or Investigational Measures and not in conflict with Generally Accepted dental standards.

Non-EPO Provider means a Dentist who has not agreed to participate in the Dental Exclusive Provider Organization (PPO) network identified by the Claims Administrator for this plan.

Non-PPO Provider means a Dentist who has not agreed to participate in the Dental Preferred Provider Organization (PPO) network identified by the Claims Administrator for this plan.

Orthodontic Treatment or Service means any Treatment or Service for:

- straightening of teeth, formal, full-banded retention and treatment, including x-rays and other diagnostic procedures; and
- removable or fixed appliances for tooth or bony structure guidance or retention.

Period of Dental Treatment means all sessions of dental care that result from the same initial diagnosis and any related complications.

Physical Handicap means a Dependent child's substantial physical or mental impairment, as determined by the Plan Administrator, which:

- results from injury, accident, congenital defect, or sickness; and
- is diagnosed by a Physician as a permanent or long term dysfunction or malformation of the body.

Physician means Doctor of Medicine (MD) or Doctor of Osteopathy (DO).

Placement for Adoption; Placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

Plan Administrator means County of Imperial.

Planholder means County of Imperial.

Preferred Provider/PPO Provider means a Dentist who has agreed to participate in the Dental Preferred Provider Organization (PPO) network identified by the Claims Administrator for this plan.

Prevailing Charges means:

- For dental care received from Exclusive Provider or Preferred Providers, the negotiated fee between the Exclusive Provider or Preferred Provider and the EPO/PPO.
- For dental care received from Non-EPO or Non-PPO Providers, the amount, as determined by the Claims Administrator, that most dental care providers charge within a geographic cost area for a Treatment or Service.

  For purposes of coverage provided under this plan, an actual charge for a Treatment or Service will be in excess of Prevailing Charges if, as determined by the Claims Administrator, 90% or more of all other charges reported to the Claims Administrator for the same (or a similar) Treatment or Service provided within the same (or a comparable) cost area are lower in amount than the actual charge.

Second Opinion means an opportunity to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed Treatment or Service to assess the clinical necessity and appropriateness of the proposed service.

Second Opinion Consultation Charges mean Covered Charges for:

- consultation with a Second Opinion Physician to obtain a Second Opinion prior to a Treatment or Service for which a Second Opinion is recommended; and
- necessary diagnostic x-ray and laboratory examinations performed in connection with such consultation.

Second Opinion Physician means a Physician or Dentist who:

- is an appropriate specialist for the particular Treatment or Service recommended; and
- is not a partner or associate of the Physician or Dentist who recommended or will perform the Treatment or Service.

Treatment or Service means treatment, service, substance, material, or device.