PHOEBE - DEVITT HOMES

Dental Plan Document

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ARTICLE ONE

PLAN SCHEDULE

PHOEBE – DEVITT HOMES
PLAN EFFECTIVE: JANUARY 1, 2020
PLAN NUMBER: K1900398

Eligible Classes: Each active, full-time employee (30 hours) and nursing employees working a designated
Weekend Program (24 hours)

Present Service Requirement: 2 months

Future Service Requirement: 2 months

Entry Date: First of the month occurring on or after completion of the service requirement

<u>EMPLOYEE AND DEPENDENT DENTAL COVERAGE INFORMATION</u>
(Dependent coverage applies only if elected)
<u>Participant's effective date on file with Plan Administrator</u>

SCHEDULE

*Deductible Amount:

	Preferred Provider Option (In-Network)	Non-Preferred Provider Option (Out-of-Network)
Individual Deductible:	$ 50	$ 50
Individual Deductible for Class IV Orthodontic Services:	$ 50	$ 50
Maximum Family Deductible: (does not apply to Class IV Orthodontic Services)	2 persons individually	2 persons individually

The deductible does not apply to Class I Preventive Services or Class II Basic Services.

*(In and Out-of-Network are common deductibles)

Benefit Percentages:	Preferred Provider Option (In-Network)	Non-Preferred Provider Option (Out-of-Network)
Class I Preventive Services:	100%	100%
Class II Basic Services:	100%	100%
Class III Major Services:	50%	50%
Class IV Orthodontic Services:	50%	50%

Benefit Maximums:		
Benefit Year Maximum:		$1,000 $1,000
Benefit maximums While Covered Under The Plan:		
Class IV Orthodontic Services:	$1,000	$1,000

Covered dental expenses are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental expenses. However, benefits will be payable based on the most current dental terminology.

NOTE: This Summary does not describe all terms, conditions and limitations. Refer to your Plan Document or contact your Benefits Manager for more details.

ERISA INFORMATION

Plan Name: Phoebe – Devitt Homes

Plan Sponsor (also referred to herein as Plan Administrator, unless otherwise specified):

Phoebe – Devitt Homes
1925 Turner Street
Allentown PA 18104
Ph: 610-794-5176

Employer Identification Number (EIN): 23-1396838

Plan Number: 507

Plan Administrator: Same as Plan Sponsor

Designated Agent for
service of legal process: Lisa Fichera – SVP Administration

or the Plan Administrator.

Plan Administrator: The *Plan* is administered by the *Plan Administrator* with Sun Life Assurance Company of Canada/Sun Life and Health Insurance Company (U.S.), 2323 Grand Boulevard, Kansas City, Missouri 64108, acting as *Dental Claims Administrator*.

Type of Administration: Self-administered with third party claims administration.

Plan Contributions: Employer and Employee, jointly

Trust Fund: N/A

Plan Year: November 1 through October 31

Participating Employers: None

ARTICLE TWO

DEFINITIONS

These terms have the meanings shown here when italicized.

Active work means working full-time for an Employer at the Employee's usual place of business.

Adopting Employer means the Plan Sponsor.

Benefit year means a calendar year beginning on January 1 of any year and ending on December 31 of that year.

Claimant means an individual who has submitted an application for benefits under the Plan.

Contributory means the Participant pays part or all of the Plan costs and/or benefits through contributions from the Participant.

Covered dependent means an eligible dependent who is covered under the Plan.

Dental Claims Administrator means the person, insurance company or other entity which has accepted appointment by the Plan Administrator to provide certain administrative services with respect to the Plan.

Dental coverage means the group dental coverage under the Plan.

Dental hygienist means an individual who is licensed to practice dental hygiene and acting under the supervision of a dentist within the scope of that license in treating the dental condition.

Dentally necessary and dental necessity mean a treatment appropriate for the diagnosis and in accordance with accepted dental standards. The treatment must be essential for the care of the teeth and supporting tissues.

Dental treatment plan means the dentist's report of recommended treatment which contains:

(a) a list of the charges and dental procedures required for the dentally necessary care;

(b) any supporting X-rays; and

(c) any other appropriate diagnostic materials required.

Dentist means an individual who is licensed to practice dentistry and acting within the scope of that license in treating the dental condition.

Denturist means an individual who is licensed to make dentures and acting within the scope of that license in treating the dental condition.

Doctor means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. Also, a person whom we are required to recognize as a doctor by the laws or regulations of the governing jurisdiction, or a person who is legally licensed to practice psychiatry, psychology or psychotherapy and whose primary work activities involve the care of patients, is a doctor. However, neither you nor an immediate family member will be considered a doctor.

Eligible class means class of persons eligible to participate under the Plan.

Emergency dental care means any dentally necessary treatment rendered or received as the direct result of unforeseen events or circumstances which require prompt attention.

Employer means and includes the Adopting Employer and any and all Participating Employers.

Employee means any person employed by an Employer. An Employee may or may not be a Participant.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time, and the regulations as amended from time to time and rulings in effect thereunder.

Family unit means a Participant and his covered dependents.

Full-Time means working at least 24 to 30 hours per week.

Functioning natural tooth means a natural tooth which is performing its normal role in the chewing process in the person's upper or lower arch and which is opposed in the person's other arch by another natural tooth or prosthetic replacement.

Fund or Trust Fund means any Fund or Trust Fund maintained in connection with the Plan.

Immediate family member means a person who is related to the Participant in one of the following ways: parent, legally recognized spouse, child or step-child, brother or sister.

Injury means accidental bodily injury. It does not mean intentionally self-inflicted injury while sane or insane.

Medicare means a portion of Title XVIII of the United States Social Security Act of 1965, as amended.

Natural tooth means any tooth or part of a tooth that is formed by the natural development of the body. Organic portions of the tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp.

No-Fault motor vehicle coverage means a motor vehicle plan that pays disability or medical benefits without considering who was at fault in any accident that occurs.

Noncontributory means the Adopting Employer or Participating Employer pays for the entire Plan costs and benefits.

Orthodontic treatment means the procedures which provide the corrective movement of teeth through the bone by means of an active appliance to correct a handicapping malocclusion (a malocclusion severely interfering with a person's ability to chew food). Determination of the severity of the malocclusion will be made by the Dental Claims Administrator.

Other group dental expense coverage means:

(a) any other group plan providing benefits for dental expenses; or

(b) any plan providing dental expense benefits (whether through a dental services organization or other party providing prepaid health or related services) which is arranged through any employer or through direct contact with persons eligible for that plan.

Participant means an eligible Employee of an Employer who participates in the Plan.

Participating Employer means any Employer participating in the Plan as designated by the Adopting Employer.

Periodontal maintenance procedures mean recall procedures for patients who have undergone either surgical or non-surgical treatment for periodontal disease. The procedures include examination,

periodontal evaluation and any further scaling and root planing that is dentally necessary.

Plan means the group dental plan established by the Adopting Employer that describes benefits for Participants and their covered dependents.

Plan Administrator shall have the same meaning as provided in ERISA.

Plan Sponsor shall have the same meaning as provided in ERISA.

Pre-estimate review means review of a dentist's statement, including diagnostic X-rays, describing the planned treatment and expected charges.

Preferred provider means a dentist, dental hygienist, dental office or any dental care provider who is a participant in the preferred provider option.

Preferred provider option means a dental care delivery system in which preferred providers participate and under which certain dental benefits are provided.

Treatment means any dental consultation, service, supply, or procedure that is needed for the care of the teeth and supporting tissues.

Trust means the Trust established under the Trust Agreement.

Trust Agreement means the agreement concerning the Fund as amended from time to time.

Trustee means the entity acting as Trustee under the Trust Agreement.

Usual and customary (UC) charge means:

(a) Usual charge is the fee regularly charged for a treatment to the majority of a dentist's patients and accepted as payment in full by an individual dental office. If more than one fee is charged, the fee determined to be the usual fee will not be greater than the lowest fee which is regularly charged or offered to patients.

(b) Customary charge is the fee for a given treatment, which does not exceed the amount ordinarily charged by the majority of dentists in the locality. Locality is either a county or such geographically significant area as is necessary to establish a representative base of charges for the type of treatment for which the charge is made.

ARTICLE THREE

ELIGIBILITY AND TERMINATION PROVISIONS

Eligible Persons

To be eligible for participation, a person must:

(a) be a member of an eligible class; and

(b) complete any Service Requirement shown in the Schedule by continuous service with the Employer.

The Present Service Requirement applies to persons in an eligible class on the Effective Date of the Plan. The Future Service Requirement applies to persons who become members of an eligible class after that.

Effective Date for an Eligible Person

(1) Any noncontributory participation will take effect on the Entry Date shown in the Schedule.

(2) For any contributory participation, a person must apply for participation on an acceptable form, and agree to pay part or all of the cost of participation.

(a) If a person applies before becoming eligible, participation will begin on the Entry Date shown in the Schedule.

(b) If application is made on the date the person becomes eligible, or within 31 days after that, participation will take effect on the date of the application.

(c) If application is made more than 31 days after the day the person becomes eligible or after participation ended because the cost of contribution was not paid, then dental coverage will take effect on the date of application. However, for the first 12 months of participation under the Plan, the Late Entrant Limitation in the Special Limitations section will apply.

(d) If application is made during the Employer's annual open enrollment period held between November 1 and December 31 of each year, participation will take effect on January 1 of that year.

Exception to Effective Date

If an eligible person is not at active work on the day participation would otherwise take effect, participation will not take effect until the person returns to active work. If the day participation would normally take effect is not a regular work day for a person, coverage will take effect on that day if the person is able to do his regular job.

When a Participant's Participation Ends

A Participant's participation will end on:

(a) the date the Plan ends;

(b) the date the Plan is changed to terminate participation for a Participant's eligible class;

(c) the last day of the month following the date a Participant is no longer in an eligible class;

(d) the last day of the month following the date a Participant stops active work;

(e) the date a required contribution was not paid; or

(f) the date a Participant becomes covered under an optional dental plan which is:

  (i) provided by a Dental Maintenance Organization; and

  (ii) sponsored by the Employer.

Continuance of Participation

If a Participant is unable to perform active work for a reason shown below, the Employer may continue the Participant's participation. The continuance cannot be more than the maximum continuance shown below. Continuance will be based on a uniform policy, and not individual selection.

The maximum continuance is the longest applicable period described below:

(a) 12 months after the last day of active work, for injury, sickness, or pregnancy;

(b) 3 months after the last day of active work, for lay-off, leave of absence (other than a family or medical leave of absence described below), or change to part-time; or

(c) the end of the period the Employer is required to allow after the last day of active work, for a family or medical leave of absence under;

  (i) the federal Family and Medical Leave Act; or

  (ii) any similar state law.

Reinstatement

If a person re-enters an Eligible Class within 12 months after participation ends, the person will not have to complete the Service Requirement again.

ARTICLE FOUR

ELIGIBILITY AND TERMINATION PROVISIONS FOR YOUR DEPENDENTS

Eligible Dependents

A Participant's eligible dependents are:

(a) the Participant's lawful spouse, and

(b) the Participant's unmarried children who are less than age 19, or less than age 23 if a full-time student.

"Children" include any adopted children. A child will be considered adopted on the date of placement in the Participant's home. Stepchildren and foster children are also included if they depend on the Participant for support and maintenance. “Children” also include any children for whom the Participant is the legal guardian, who reside with the Participant on a permanent basis and depend on the Participant for support and maintenance.

An eligible dependent will not include any person who is a member of an eligible class. An eligible dependent may not be covered by more than 1 Participant.

Dependent Effective Date

(1) Any noncontributory dependent participation will take effect on the day the dependent becomes an eligible dependent, or, if later, on the Entry Date shown on the Schedule.

(2) For any contributory dependent participation, the Participant must apply for dependent participation on an acceptable form. The Participant must also agree to pay all or part of his share of the cost of dependent participation.

(a) If the Participant applies before the dependent becomes eligible, dependent participation will take effect on the Entry Date shown in the Schedule.

(b) If the Participant applies on the date the dependent becomes eligible, or within 31 days after that, dependent participation will take effect on the date of the application.

(c) If the Participant applies more than 31 days after the dependent becomes eligible or after dependent participation ended because the cost of coverage was not paid, dependent participation will take effect on the date of application. However, for the first 12 months after the dependent's participation under the Plan, the Late Entrant Limitation in the Special Limitations section will apply.

(d) If the Participant applies for dependent participation during the Employer's annual open enrollment period held between November 30 and December 31 of each year, dependent participation will take effect on January 1 of that year.

Exception to Dependent Effective Date

Dependent participation will not take effect until employee participation coverage under the Plan takes effect.

If an eligible dependent is in a hospital or similar facility on the day participation would otherwise take effect, it will not take effect until the day after the eligible dependent leaves the hospital or similar facility. This exception does not apply to a child born while other dependent participation is in effect.

When Dependent Participation Ends

A dependent's participation will end on:

(a) the date the Plan ends;

(b) the date the Plan is changed to end dependent participation;

(c) the last day of the month following the date that dependent is no longer eligible;

(d) the date the Employee's participation for under the Plan ends;

(e) the date a required contribution for dependent participation was not paid; or

(f) the date the dependent becomes covered under an optional dental plan which is:

   (i) provided by a Dental Maintenance Organization; and

   (ii) sponsored by the Employer.

ARTICLE FIVE

SPECIAL DEPENDENT CONTINUANCE PROVISIONS

As specified below, dependent participation may continue, subject to the provisions that describe when participation ends, and all other terms and conditions of the Plan. Contributions are required for any continued participation.

Physically Handicapped or Mentally Retarded Dependent Children

Participation for an eligible dependent child will continue beyond the date a child attains an age limit, if, on that date, the child:

(a) is unable to earn a living because of physical handicap or mental retardation; and

(b) is chiefly dependent upon the Participant for support and maintenance.

Proof must be received of the above within 31 days after the child attains the age limit and each year after that, beginning two (2) years after the child attains the age limit. There will be no increase in cost of participation for this continuance.

Dependent participation will end when the child is able to earn a living or is no longer dependent on the Participant for support and maintenance.

Students

Participation for an eligible dependent child will continue beyond the date the child is no longer a student until the earliest of:

(a) the end of the 3rd calendar month following the month in which the child is no longer a student;

(b) the child's 23rd birthday; and

(c) the date the child becomes eligible for other group dental expense coverage.

ARTICLE SIX

DENTAL PLAN BENEFITS

Benefits Provided

The Plan will provide benefits for covered dental expenses identified in the Plan when incurred by the Participant or a covered dependent, while participating under the Plan. The Plan will pay at the benefit percentage shown in the Schedule after the Participant or a covered dependent have satisfied any deductible required for the benefit year, subject to all the terms and conditions of the Plan.

Covered dental expenses will only include treatment provided to the Participant or a covered dependent for which, as outlined in the Covered Dental Expenses section, the date started and the date completed occur while the person is participating in the Plan. No payment will be made for a program of dental treatment already in progress on the effective date of a person's participation in the Plan, except as stated in the Effect of Prior Plan provision. No payment will be made for dental treatment completed after the Participant's or a covered dependent's participation under the Plan ends.

Preferred Provider Option

Benefits of the preferred provider option will be provided, as shown in the Schedule, for covered expenses incurred by the Participant or a covered dependent if the treatment is provided by a preferred provider. The Participant or a covered dependent must be identified as being covered under the preferred provider option each time treatment is received, to obtain the benefits of the preferred provider option. Benefits will be provided under the non-preferred provider option, as shown in the Schedule, for covered dental expenses incurred by the Participant or a covered dependent if the treatment is provided by a dental care provider who is not a participant in the preferred provider option.

Deductible

The deductible is the amount shown in the Schedule and will be applied to each class of dental services as indicated in the Schedule. The deductible is the amount of covered dental expenses that the Participant and each covered dependent must incur in a benefit year before benefits will be paid. When covered dental expenses equal to the deductible amount have been incurred and submitted, the deductible will be satisfied. Benefits will not be paid for covered dental expenses applied to the deductible.

If the deductible amount is increased during a benefit year, further covered dental expenses must be incurred after the date of increase to satisfy the additional deductible for that benefit year.

The deductible will apply to the Participant and each covered dependent separately each benefit year except as stated in the Maximum Family Deductible section.

Maximum Family Deductible

The family deductible is shown in the Schedule. It indicates the number of persons in the Participant's family unit who must each satisfy an individual deductible in order to satisfy the family deductible. Once that number of persons has satisfied a deductible for a benefit year, the deductible will be considered satisfied for each person in the Participant's family unit for that benefit year. Benefits will be paid for covered dental expenses incurred on or after the date the required number of persons has satisfied the deductible amount. Expenses incurred for Class IV: Orthodontic Dental Services will not be applied to the family deductible.

Benefit Year Maximum

The maximum benefit payable during a benefit year is shown in the Schedule. This maximum will apply even if coverage for the Participant or a covered dependent ends and starts again within the same benefit

year or if the Participant or a covered dependent have been covered both as an Participant and a dependent.

Termination of a Preferred Provider's Participation under the Preferred Provider Option

If the Participant or a covered dependent incur covered dental expenses with a preferred provider after the provider's participation in the preferred provider option has ended, benefits will not be payable for the Participant or the covered dependent under the preferred provider option. However, benefits will be provided under the non-preferred provider option shown in the Schedule.

Termination of the Plan's Participation under the Preferred Provider Option

If the Participant or a covered dependent incur covered dental expenses with a preferred provider after the Plan's participation in the preferred provider option has ended, for any reason, benefits will not be payable for the Participant or the covered dependent under the preferred provider option. However, benefits will be provided under the non-preferred provider option shown in the Schedule.

Covered Dental Expenses

Covered dental expenses include only the lesser of the amount agreed upon by the preferred provider under the preferred provider option, the dentist's actual charge, or the usual or customary charge for expenses incurred by you or a covered dependent. The treatment must be:

(a) performed by or under the direction of a dentist, or performed by a dental hygienist or denturist;

(b) dentally necessary; and

(c) started and completed while the Participant or the Participant's covered dependent are participating under the Plan, except as otherwise provided in the Effect of Prior Plan.

Dental treatment is considered to be started as follows:

(a) for a full or partial denture, the date the first impression is taken;

(b) for a fixed bridge, crown, inlay and onlay, the date the teeth are first prepared;

(c) for root canal therapy, on the date the pulp chamber is first opened;

(d) for periodontal surgery, the date the surgery is performed; and

(e) for all other treatment, the date treatment is rendered.

Dental treatment is considered to be completed as follows:

(a) for a full or partial denture, the date a final completed appliance is first inserted in the mouth;

(b) for a fixed bridge, crown, inlay and onlay, the date an appliance is cemented in place; and

(c) for root canal therapy, the date a canal is permanently filled.

(See Class IV: Orthodontic Dental Services for start and completion dates for orthodontic treatment.)

Expenses submitted must identify the treatment performed in terms of the American Dental Association

Uniform Code on Dental Procedures and Nomenclature or by narrative description. The Plan reserves the right to request X-rays, narratives and other diagnostic information, as seen fit, to determine benefits.

Benefits will only be paid for covered dental expenses incurred for treatment which, was determined to have a reasonably favorable prognosis for the patient.

A temporary treatment will be considered to be an integral part of the final treatment. The sum of the fees for temporary and final treatment will be used to determine whether the charges are usual and customary.

The following is a complete list of covered dental expenses. Benefits will not be paid for expenses incurred for any service not listed in the Plan.

CLASS I: Preventive Dental Services

(1) periodic or comprehensive oral evaluation, limited to 1 time in any 6-month period;

(2) intraoral complete series X-rays, including bitewings and 10 to 14 periapical X-rays, or panoramic film, limited to 1 time in any 60-month period;

(3) bitewing X-rays (2 or 4 films), limited to 1 time in any 12-month period;

(4) dental prophylaxis, limited to 1 time in any 6-month period;

(5) topical fluoride treatment, limited to:

  (a) 1 time in any 6-month period; and

  (b) covered dependent children less than age 19;

(6) sealants, limited to:

  (a) 1 time per tooth in any 36-month period;

  (b) applications made to permanent molar teeth; and

  (c) covered dependent children less than age 14;

(7) space maintainers, including all adjustments made within 6 months of installation, limited to covered dependent children less than age 19.

CLASS II: Basic Dental Services - Non-Restorative

(1) limited oral evaluation-problem focused, considered for payment as a separate benefit only if no other treatment (except X-rays) is rendered during the visit;

(2) intraoral periapical X-rays;

(3) intraoral occlusal X-rays, limited to 1 film in any 6-month period;

(4) extraoral X-rays, limited to 1 film in any 6-month period;

(5) other X-rays (except films related to orthodontic procedures or temporomandibular joint dysfunction);

(6) histopathological examination;

(7) stainless steel crowns, limited to:

    (a) 1 time in any 36-month period;

    (b) teeth not restorable by an amalgam or composite filling; and

    (c) covered dependent children less than age 19;

(8) pulpotomy;

(9) root canal therapy, including all pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care, limited to 1 time on the same tooth in any 24-month period;

(10) apicoectomy/periradicular surgery (anterior, bicuspid, molar, each additional root), including all pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care;

(11) retrograde filling--per root;

(12) root amputation--per root;

(13) hemisection, including any root removal and an allowance for local anesthesia and routine post-operative care, does not include a benefit for root canal therapy;

(14) periodontal scaling and root planing (per quadrant), limited to 1 time per quadrant of the mouth in any 24-month period;

(15) periodontal maintenance procedure (following active treatment), limited to 1 dental prophylaxis or 1 periodontal maintenance procedure in any 6-month period;

(16) periodontal related services as listed below, limited to 1 time per quadrant of the mouth in any 36-month period with charges combined for each of these services performed in the same quadrant within the same 36-month period:

    (a) gingivectomy;

    (b) osseous surgery;

(17) osseous grafts;

(18) pedicle grafts;

(19) tissue grafts;

(20) periodontal appliances, limited to 1 appliance in any 12-month period;

(21) simple extraction;

(22) oral surgery services as listed below, including an allowance for local anesthesia and routine post-operative care;

    (a) surgical extractions (including extraction of wisdom teeth);

    (b) alveoloplasty;

(c) vestibuloplasty;

(d) removal of exostosis--maxilla or mandible;

(e) frenulectomy (frenectomy or frenotomy);

(f) excision of hyperplastic tissue--per arch;

(23) tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus;

(24) extraction, erupted tooth or exposed root (elevation and/or forceps removal);

(25) biopsy;

(26) incision and drainage;

(27) palliative (emergency) treatment of dental pain, considered for payment as a separate benefit only if no other treatment (except X-rays) is rendered during the visit;

(28) general anesthesia, intravenous sedation and use of nitrous oxide when administered in the dentist's office or outpatient surgical center in conjunction with services which are covered under the Plan;

(29) consultation, including specialist consultations, limited as follows:

(a) considered for payment only if billed by a dentist who is not providing operative treatment;

(b) benefits will not be considered for payment if the purpose of the consultation is to describe the dental treatment plan;

(30) therapeutic drug injections.

CLASS II: Basic Dental Services - Restorative

(1) amalgam restorations, limited as follows:

(a) multiple restorations on one surface will be considered a single filling;

(b) benefits for the replacement of an existing amalgam restoration will only be considered for payment if at least:

(i) 12 months have passed since the existing amalgam restoration was placed if the Participant or covered dependent is less than age 19; or

(ii) 36 months have passed since the existing amalgam restoration was placed if the Participant or covered dependent is age 19 or older;

(c) mesial, lingual, buccal (MLB) and distal, lingual, buccal (DLB) restorations will be considered single surface restorations;

(2) silicate restorations;

(3) plastic restorations;

(4) composite restorations, limited as follows:

  (a) mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations;

  (b) acid etch is not covered as a separate procedure;

  (c) benefits for the replacement of an existing composite restoration will only be considered for payment if at least:

    (i) 12 months have passed since the existing composite restoration was placed if the Participant or covered dependent is less than age 19; or

    (ii) 36 months have passed since the existing composite restoration was placed if the Participant or covered dependent is age 19 or older;

  (d) benefits for composite resin restorations on posterior teeth will be based on the benefit for the corresponding amalgam restoration;

(5) pin retention restorations, covered only in conjunction with an amalgam or composite restoration, pins limited to 1 time per tooth.

CLASS III: Major Dental Services

All benefits for the services listed below include an allowance for all temporary restorations and appliances, and 1 year follow-up care.

(1) inlays and onlays;

  (a) covered only when the tooth cannot be restored by an amalgam or composite filling;

  (b) covered only if more than 10 years have elapsed since last placement; and

  (c) limited to persons over age 16;

(2) porcelain restorations on anterior teeth;

(3) crowns;

  (a) covered only when the tooth cannot be restored by an amalgam or composite filling;

  (b) covered only if more than 10 years have elapsed since last placement; and

  (c) limited to persons over age 16;

(4) recementing inlays;

(5) recementing crowns;

(6) crown build-up, including pins and prefabricated posts;

(7) post and core, covered only for endodontically treated teeth requiring crowns;

(8) full dentures, limited as follows:

(a) limited to 1 time per arch unless:

(i) 10 years have elapsed since last replacement; and

(ii) the denture cannot be made serviceable;

(b) additional benefits will not be paid for personalized dentures or overdentures or associated treatment;

(c) any denture will not be paid until it is accepted by the patient;

(9) partial dentures, including any clasps and rests and all teeth, limited as follows:

(a) limited to 1 partial denture per arch unless:

(i) 10 years have elapsed since last replacement (see the Denture or Bridge Replacement/Addition provision for exceptions); and

(ii) the partial denture cannot be made serviceable;

(b) there are no benefits for precision or semi-precision attachments;

(10) denture adjustments, limited to:

(a) 1 time in any 12-month period; and

(b) adjustments made more than 12 months after the insertion of the denture;

(11) repairs to full or partial dentures, bridges, crowns and inlays, limited to repairs or adjustments performed more than 12 months after the initial insertion;

(12) relining or rebasing dentures, limited to:

(a) 1 time in any 36-month period; and

(b) relining or rebasing done more than 12 months after the insertion of the denture;

(13) tissue conditioning, limited to repairs or adjustment performed more than 12 months after the initial insertion of the denture;

(14) fixed bridges (including Maryland bridges), limited as follows:

(a) limited to persons over age 16;

(b) benefits for the replacement of an existing fixed bridge are payable only if the existing bridge:

(i) is more than 10 years old (see the Denture or Bridge Replacement/Addition provision for exceptions); and

(ii) cannot be made serviceable;

(c) a fixed bridge replacing the extracted portion of a hemisected tooth is not covered;

(d) the date the bridge is cemented in the mouth will used in determining the amount that will be applied to the benefit year Maximum shown in the Plan Schedule;

(15) recementing bridges, limited to repairs or adjustment performed more than 12 months after the initial insertion;

CLASS IV: Orthodontic Dental Services

(1) cephalometric X-rays;

(2) diagnostic casts, limited to casts made for orthodontic purposes;

(3) surgical exposure of an impacted tooth, limited to services performed for orthodontic purposes;

(4) orthodontic appliances for tooth guidance; and

(5) fixed or removable appliances to correct harmful habits.

Benefits for orthodontic treatment will be provided to covered dependent children only.

Benefits for orthodontic treatment are not payable for expenses incurred for retention of orthodontic relationships. Benefits for orthodontic treatment are payable only for active orthodontic treatment for the services listed above.

Benefits will be paid for the orthodontic services listed above when the date started for the orthodontic service occurs while the person is covered under this Plan. No payment will be made for orthodontic treatment if the appliances or bands are inserted prior to becoming covered except as provided in the Effect of Prior Plan provision. Orthodontic treatment will be considered to be started on the date the bands or appliances are inserted. Any other orthodontic treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the orthodontic treatment is rendered.

The benefit percentage amount shown in the Schedule will be paid after any required deductible for orthodontic services has been satisfied for the benefit year. The maximum benefit payable to each covered dependent child, while covered under the Plan, for orthodontic services is shown in the Schedule. The maximum benefit will apply even if coverage is interrupted. Benefits paid for orthodontic services will not be applied to the Benefit Year Maximum shown in the Schedule.

A payment will be made for covered orthodontic services related to the initial orthodontic treatment which consists of diagnosis, evaluation, pre-care and insertion of bands or appliances. After the payment for the initial orthodontic treatment, benefits for covered orthodontic services will be paid in equal quarterly installments over the course of the remaining orthodontic treatment. The benefit payment schedule for the initial orthodontic treatment and quarterly installments will be determined as follows:

(1) The lesser of the usual or customary charge and the orthodontist's fee will be determined and multiplied by the benefit percentage shown in the Schedule.

(2) The lesser of the amount from number 1 or the Overall Maximum Benefit for orthodontic services shown in the Schedule will be the maximum benefit payable. An initial amount of 25% of the maximum benefit payable will be paid for the initial orthodontic treatment. This amount will be payable as of the date appliances or bands are inserted.

(3) The remaining 75% of the maximum benefit payable will be divided by the number of quarters that orthodontic treatment will continue to determine the amount which will be payable for each subsequent quarter of orthodontic treatment. The subsequent quarterly

payments will made only if the covered dependent child remains covered under the Plan and provides proof that orthodontic treatment continues. If orthodontic treatment continues after the maximum benefit payable has been paid, no further benefits will be paid.

Pre-estimate

If the charge for any treatment is expected to exceed $300, it is recommended that a dental treatment plan be submitted for review before treatment begins. An estimate of the benefits payable will be sent to the Participant and the dentist.

In addition to a dental treatment plan, before orthodontic treatment begins, the Dental Claims Administrator may request any of the following information to help determine benefits payable for orthodontic services:

(1) full mouth dental X-rays;

(2) cephalometric X-rays and analysis;

(3) study models; and

(4) a statement specifying:

  (a) degree of overjet, overbite, crowding and open bite;

  (b) whether teeth are impacted, in crossbite, or congenitally missing;

  (c) length of orthodontic treatment; and

  (d) total orthodontic treatment charge.

In estimating the amount of benefits payable, the Plan will consider whether or not an alternate treatment may accomplish a professionally satisfactory result. If the Participant or a covered dependent and the dentist agree to a more expensive treatment than that pre-estimated under the Plan, the excess amount will not be paid.

The pre-estimate is not an agreement for payment of the dental expenses. The pre-estimate process lets the Participant or a covered dependent know in advance approximately what portion of the expenses will be considered covered dental expenses under the Plan.

Alternate Treatment

If an alternate treatment can be performed to correct a dental condition, the maximum covered dental expense consider for payment under the Plan will be the most economical treatment which will, as determined by the Dental Claims Administrator, produce a professionally satisfactory result.

Special Limitations

Late Entrant Limitation

If an employee applies for dental coverage more than 31 days after the employee or any eligible dependents first become eligible or after participation in the Plan ended because a required contribution was not paid, the employee and any eligible dependents are late entrants. The benefits for the first 24 months of coverage for late entrants will be limited as follows:

(a) Until the late entrant has been covered under the Plan for 6 months in a row, benefits will

include coverage for only Class I Dental Services;

(b) Until the late entrant has been covered under the Plan for 12 months in a row, benefits for the second 6 months will then include coverage for only Class I and Class II Restorative Dental Services; and

If treatment for a service limited under this provision is started during the Late Entrant Limitation period, only the portion of the treatment rendered after the end of the Late Entrant Limitation period will be considered a covered dental expense.

Missing Teeth Limitation

Benefits will not be paid for replacement of teeth missing on the Participant's or a covered dependent's effective date of participation under the Plan for the purpose of the initial placement of a full denture, partial denture or fixed bridge. However, expenses for the replacement of teeth missing on the effective date of participation will be considered for payment as follows:

(a) The initial placement of full or partial dentures will be considered a covered dental expense if the placement includes the initial replacement of a functioning natural tooth extracted while the Participant or covered dependent are participating under the Plan.

(b) The initial placement of a fixed bridge will be considered a covered dental expense if the placement includes the initial replacement of a functioning natural tooth extracted while the Participant or covered dependent are participating under the Plan. However, the following restrictions will apply:

(i) the extracted tooth will not be considered a covered dental expense if it was an abutment to an existing prosthesis;

(ii) benefits will only be paid for the replacement of the teeth extracted while the Participant or covered dependent are participating under the Plan;

(iii) benefits will not be paid for the replacement of other teeth which were missing on the Participant's or covered dependent's effective date of participation under the Plan.

Denture or Bridge Replacement/Addition

As stated in the Covered Dental Expenses section, benefits will not be paid for the replacement of a full denture, partial denture, fixed bridge or for teeth added to a partial denture unless:

(a) 10 years have elapsed since last replacement of the denture or bridge; and

(b) the denture or bridge cannot be made serviceable;

(c) the Participant or covered dependent has participated in the Plan for 12 consecutive months;

However, the following exceptions will apply:

(a) benefits for the replacement of an existing partial denture that is less than 10 years old will be payable if there is a dentally necessary extraction of an additional functioning natural tooth;

(b) benefits for the replacement of an existing fixed bridge that is less than 10 years

old will be payable if:

(i) there is a dentally necessary extraction of an additional functioning natural tooth; and

(ii) the extracted tooth was not an abutment to an existing bridge.

General Exclusions

Benefits will not be paid for expenses incurred for any of the following:

(1) treatment which:

(a) is not included in the list of covered dental expenses;

(b) is not dentally necessary;

(c) is experimental in nature; or

(d) does not have uniform professional endorsement;

(2) appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting;

(3) any treatment or appliance, the sole or primary purpose of which relates to:

(a) the change or maintenance of vertical dimension;

(b) the alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery or temporomandibular joint disorder;

(c) bite registration; or

(d) bite analysis;

(4) replacement of a lost or stolen appliance or prosthesis;

(5) educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions;

(6) completion of claim forms or missed dental appointments;

(7) personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders;

(8) treatment for a jaw fracture;

(9) treatment provided by a dentist, dental hygienist, denturist or doctor who is:

(a) an immediate family member or a person who ordinarily resides with the Participant or a covered dependent;

(b) an employee of the Employer; or

(c) an Employer;

(10) hospital or facility charges for room, supplies or emergency room expenses; or routine chest X-rays and medical exams prior to oral surgery;

(11) treatment performed outside the United States, except for emergency dental care. The maximum benefit payable to any person during a benefit year for covered dental expenses related to emergency dental care performed outside the United States is $100;

(12) treatment resulting from or in the course of the Participant's or a covered dependent's regular occupation for pay or profit for which the Participant or covered dependent are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. The Participant must promptly claim and notify the Plan of all such benefits;

(13) treatment for which these conditions exist:

(a) charges are payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, any state or local medical assistance (Medicaid) agency for covered dental expenses will always be reimbursed;

(b) charges are not imposed against the person or for which the person is not liable;

(c) charges are reimbursable by Medicare Part A & Part B.* If a person at any time was entitled to enroll in the Medicare program (including Part B) but did not do so, his benefits under the Plan will be reduced by any amount that would have been reimbursed by Medicare, where permitted by law;

* However, for persons covered under Employers who employed 20 or more employees during the previous business year, this exclusion will not apply to an actively working Participant and/or his spouse who is age 65 or older if the Participant elects to participate under the Plan instead of obtaining coverage under Medicare.

(14) treatment provided primarily for cosmetic purposes;

(15) treatment which may not reasonably be expected to successfully correct the person's dental condition for a period of at least 3 years, as determined by the Dental Claims Administrator;

(16) crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;

(17) Implants;

(18) Temporomandibular Joint (TMJ) treatment.

Effect of Prior Plan

This provision applies only to Participants and their covered dependents who elect to participate on the effective date of the Plan, unless otherwise specified below.

Definitions

Prior plan means the Employer's plan of group dental insurance that was replaced by the Plan.

Continuity of Coverage for Participants

The Plan will provide continuity of coverage if the Participant was covered under the prior plan on the day before coverage was replaced by the Plan.

If the Participant

(a) is at active work on the Effective Date of the Plan and

(b) applies for coverage before or within 31 days of the Effective Date of the Plan,

the Participant will be covered under the Plan.

If the Participant is not at active work on the Effective Date of the Plan, the Participant will be covered by the Plan and will be provided the benefits of the Plan until the earliest of:

(a) the end of any period of continuance of the prior plan;

(b) the date a required contribution, if any, was not paid; or

(c) the date coverage ends, according to the provisions of the Plan.

Continuity of Coverage for Eligible Dependents

We will provide continuity of coverage for the Participant's eligible dependents, if any, who were covered under the prior plan on the day before coverage was replaced by the Plan.

If

(a) the dependent is not in a hospital or similar facility on the Effective Date of the Plan, and

(b) the Participant applies for dependent coverage before or within 31 days of the Effective Date of the Plan,

the dependent will be covered under the Plan.

If the dependent is in a hospital or similar facility on the Effective Date of the Plan, the dependent will be covered by the Plan and will be provided the benefits of the Plan until the earliest of:

(a) the end of any period of continuance of the prior plan; or

(b) the date a required contribution, if any, was not paid; or

(c) the date coverage ends, according to the provisions of the Plan.

Prior Extractions

If treatment is dentally necessary due to an extraction which occurred before the effective date of this Plan but while the Participant or covered dependent were covered under the prior plan and treatment would have been covered under the Employer's prior plan, the Coverage for Treatment in Progress provision will be applied as stated below and expenses will be considered as follows:

(a) the replacement of the extracted tooth must take place within 12 months of extraction; and

(b) expenses must be covered dental expenses under this Plan and the prior plan.

Late Entrant Limitations

If the Participant or a covered dependent:

(a) was eligible but not covered under the prior plan on the day before the prior plan was replaced by this Plan;

(b) is eligible to participate on the effective date of this Plan; and

(c) the employee elects participation under this Plan before or within 31 days of the effective date of this Plan,

then the Participant and any covered dependents will be subject to the Late Entrant Limitation in the Special Limitations section.

Coverage for Treatment in Progress

If the Participant or a covered dependent was covered under the prior plan on the day before the prior plan was replaced by this Plan, benefits will be paid for any program of dental treatment already in progress on the effective date of this Plan as stated below. However, the expenses must be covered dental expenses under this Plan and the prior plan.

Extension of Benefits under Prior Plan

This Plan will not pay benefits for treatment if:

(a) the prior plan has an extension of benefits provision;

(b) the treatment expenses were incurred under the prior plan; and

(c) the treatment was completed during the prior plan's extension of benefits.

No Extension of Benefits under Prior Plan

This Plan will pro-rate benefits according to the percentage of treatment performed while insured under the prior plan if:

(a) the prior plan has no extension of benefits when that plan terminates;

(b) the treatment expenses were incurred under the prior plan; and

(c) the treatment was completed while participating under this Plan.

Treatment Not Completed during Extension of Benefits

This Plan will pro-rate benefits according to the percentage of treatment performed while insured under the prior plan and during the extension if:

(a) the prior plan has an extension of benefits;

(b) the treatment expenses were incurred under the prior plan; and

(b) the treatment was not completed during the prior plan's extension of benefits.

This Plan will consider only the percentage of treatment completed beyond the extension period to determine any benefits payable under this Plan.

Maximum Benefit Credit

All paid benefits applied to the maximum benefit amounts under the prior plan will also be applied to the maximum benefit amounts under this Plan.

If the Participant had orthodontic coverage for his covered dependent children under the prior plan and the Participant's covered dependent children have orthodontic coverage under this Plan, benefits will not be paid for orthodontic expenses unless:

(a) proof is submitted that the Overall Maximum Benefit for Class IV Orthodontic Services for this Plan was not exceeded under the prior plan;

(b) orthodontic treatment was started and bands or appliances were inserted while covered under the prior plan; and

(c) orthodontic treatment is continued while participating under this Plan.

If required proof is submitted, the maximum benefit for orthodontic treatment will be the lesser of this Plan's Overall Maximum Benefit for Class IV Orthodontic Services or the prior plan's maximum benefit. The maximum benefit payable for orthodontic treatment under this Plan will be reduced by the amount paid or payable under the prior plan.

ARTICLE SEVEN

COORDINATION OF BENEFITS

Applicability

All of the benefits provided under this Plan are subject to this provision.

Definitions

Allowable expense means any dentally necessary, usual and customary charge, at least a portion of which is covered under 1 or more of the programs which cover the person:

(a) for whom claim is made, and

(b) on whose account payment is legally required.

When a program provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be both an allowable expense and a benefit paid.

When benefits are reduced because the person does not comply with the provisions of a program, the amount of the reduction will not be considered an allowable expense. However, any services rendered by a non-HMO/DMO provider for which the HMO/DMO denies payment will be considered an allowable expense.

Claim period means a calendar year. A claim period will not start before a person's effective date of insurance under this Plan nor extend beyond the last day the person is covered under this Plan.

Medicaid means the Title XIX of the Social Security Act of 1965 as amended.

Program means any program which provides benefits or services for medical or dental care or treatment through:

(a) group, blanket, or franchise insurance coverage;

(b) group hospital, medical, or dental service prepayment coverage, group or individual practice or other group prepayment coverage, or group-type coverage through Health Maintenance Organizations (HMOs) or Dental Maintenance Organizations (DMOs);

(c) a labor-management trusteed plan, union welfare plan, employer or employee organization plan or any other arrangement of benefits, not available to the general public, which is based on membership in a group;

(d) coverage under government programs or coverage required or provided by any statute, except Medicaid. Benefits and services provided by Part A and Part B of Medicare are included. If the Participant or a covered dependent are eligible for, but not covered under both Part A and Part B of Medicare for any reason, the benefits or services that would have been payable if the Participant or the covered dependent had been covered, will be included, unless prohibited by state law or regulation; or

(e) no-fault motor vehicle coverage or a Motor Vehicle Financial Responsibility Act, unless prohibited by state law or regulation.

Program does not include any of the following:

(a) school accident coverage;

(b) the first $30 per day of benefits under a group or group-type hospital indemnity benefit, written on a non-expense incurred basis;

(c) Medicaid; and does not include a law or program when, by law, its benefits are in excess of those of any private or other non-governmental plan; or

(d) no-fault motor vehicle coverage or a Motor Vehicle Financial Responsibility Act, which, according to its rules, determines its benefits after the benefits of this Plan have been determined, or any optional no-fault motor vehicle coverage.

The term program will be construed separately for each policy, contract, or other arrangement for benefits or services. It will also be construed separately for:

(a) that part of any policy, contract, or other arrangement which has the right to consider the benefits or services of other programs in determining its benefits; and

(b) that part which does not.

Primary program means a program whose benefits for health care coverage must be determined without considering the existence of any other program. A program is primary if:

(a) the program has no order of benefit determination rules, or it has rules which differ from this provision; or

(b) under the order of benefit determination rules, this Plan determines its benefits first.

School accident coverage means coverage for elementary, high school, or college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

Secondary program is not a primary program, and may consider the benefits of the primary program and the benefits of any other program which, under the rules of this provision, has its benefits determined before those of that secondary program.

This provision means the provision for coordination between the benefits of this Plan and other programs.

Other definitions which may apply to this Coordination of Benefits section appear in the Definitions section of the Plan.

Order of Benefit Determination

The rules to establish the order of benefit determination for each program are as follows:

(1) A program which covers the claimant as an employee, member or subscriber (that is, other than as a dependent) will determine its benefits before a program which covers the claimant as a dependent. However, if the claimant is also a Medicare beneficiary, and as the result of the rule established by Title XVIII of the Social Security Act and implementing regulations,

    (a) the program covering the claimant as a dependent will determine its benefits before Medicare; and

    (b) Medicare will determine its benefits before the program covering the claimant as other than a dependent (e.g. a retired employee). Then the program covering the claimant as a dependent will determine its benefits before the program covering the claimant as other than a dependent.

(2) In the event that the claimant is a dependent child whose parents are not divorced or separated, benefits for the child are determined in this order:

   (a) first, the program which covers the claimant as a dependent child of the parent whose birthdate occurs earlier in a calendar year; and

   (b) second, the program which covers the claimant as a dependent child of the parent whose birthdate occurs later in the calendar year.

   If both parents have the same birthdate, benefits for the child are determined in this order:

   (a) first the program which covered the parent longer; and

   (b) second, the program which covered the other parent for a shorter period of time.

(3) If the other program does not contain this exact rule regarding dependents, then this rule will not apply, and the rules set forth in the other program will determine the order of benefits.

(4) In the event that the claimant is a dependent child whose parents are divorced or separated, benefits for the child are determined in this order:

   (a) When the parent with custody of the child has not remarried,

      (i) first, the program which covers the child as a dependent of the parent with custody; and

      (ii) second, the program which covers the child as a dependent of the parent without custody; or

   (b) When the parent with custody of the child has remarried,

      (i) first, the program which covers the child as a dependent of the parent with custody; and

      (ii) second, the program which covers that child as a dependent of the stepparent; and

      (iii) finally, the program which covers that child as a dependent of the parent without custody; or

   (c) When the parents have joint custody of the child and the court does not decree which parent is responsible for the health care expenses of the child, then benefits for the child will be determined according to the birthdate rule described above.

   (d) If the specific terms of a court decree that one parent is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the program of that parent has actual knowledge of these terms, then

      (i) first, the program of parent with financial responsibility; and

      (ii) second, the program of the other parent.

This does not apply to any claim period during which any benefits are actually paid or provided before the entity has that actual knowledge.

(e) If the specific terms of a court decree state that both parents are responsible for the health care expenses of the child but gives physical custody of the child to a particular parent, then benefits for the child will be determined according to the birthday rule described above.

(5) A program which covers the claimant as a laid-off or retired employee, or as a dependent of that person, will determine its benefits after a program covering such claimant as an employee, other than a laid-off or retired employee, or as a dependent of that person.

If a program does not have a provision regarding laid-off or retired employees, which results in each program determining its benefits after the other, then this rule will not apply.

(6) When the claimant whose coverage is provided under a federal or state continuation law is also covered under another program, benefits are determined in this order:

(a) first, the program which covers the claimant as an employee; and

(b) second, the program which covers the claimant under a continuation law.

If the other program does not have a provision regarding coverage provided under continuation laws, then this rule will not apply.

(7) When none the rules described above establish an Order of Benefit Determination, a program which has covered the claimant longer will determine its benefits before a program which has covered that claimant for a shorter period of time.

Effect on Benefits

A primary program's benefits are not reduced because of the existence of another program.

When there are more than two programs, this Plan may be a primary program to one or more other programs, and may be a secondary program to a different program(s).

When this Plan is a secondary program, benefits payable under this Plan will be reduced so that when they are added to the benefits payable under all other programs, they will not exceed the total allowable expenses incurred by the Participant or a covered dependent during the claim period. Benefits payable under any other program include the benefits that would have been payable had the claim for them been made. Except for Part A and Part B of Medicare, the Participant or covered dependent must actually be covered by the other programs.

The Plan will exclude the benefits payable under any program in determining the above reduction if:

(1) that other program contains a provision which requires it to determine its benefits after the benefits of this Plan, and

(2) the rules set forth in the Order of Benefit Determination require this Plan to decide the benefits of this Plan before the other program.

When a reduction is made, each benefit that would have been payable in the absence of this provision will be reduced proportionately or in some other manner which the Dental Claims Administrator considers fair. The reduced amount will be charged against any benefit limit of this Plan that may apply.

Right to Receive and Release Necessary Information

A claimant will furnish any information necessary to implement this provision. The Dental Claims Administrator may release or obtain any information, with respect to the claimant, which it deems necessary. This information may be released to or received from any insurer, other organization, or person. This may be done without the consent of or notice to the claimant. In so acting, the Dental Claims Administrator and Plan will be free from any liability.

Facility of Payment

When payments which should have been made under this Plan, by the terms of this provision, have been made under any other programs, the Dental Claims Administrator has the right to pay to any organization making the other payments any amounts it determines are due to satisfy the intent of this provision. Any amount paid in good faith will release the Plan from further liability for that amount.

Recovery of Payment

If the Dental Claims Administrator pays more than the maximum amount required to satisfy the intent of this provision at that time, the Dental Claims Administrator has the right to recover the excess paid. Recovery may be made from any persons to, or for, or with respect to whom the payments were made, or from any other insurers or organizations. This includes the reasonable cash value of any benefits provided as a service.

ARTICLE EIGHT

CLAIM PROVISIONS

Filing of Claim

As a condition to the receipt of benefits, a Participant covered by the Plan who has a claim for benefits under the Plan must give written notice of such claim to the Plan Administrator on the application form specified by the Plan Administrator for that purpose. As a further condition to the receipt of benefits, a Participant must submit such notice of claim at any time before the end of 30 days after the date after any covered loss occurs, or within a reasonable time thereafter. The time limit for submitting a notice of claim is 90 days after the date of the loss. All applications for benefits under the Plan shall be submitted, with such information as the application shall require, to the Dental Claims Administrator. The application form must be completed by the Employer, claimant and the dentist providing dental treatment to the claimant. The preferred provider will send notice of all dental expenses incurred under the preferred provider option.

Time of Payment of Claim

After the Dental Claims Administrator has reviewed the claim form and obtained any other information deemed necessary to render a decision on the claim, the Dental Claims Administrator shall notify the claimant within 30 days after receipt of all data necessary to recommend the acceptance or denial of the claimant's claim. Unless circumstances beyond the control of the Plan require an extension of time for processing the claim such recommendation shall be made within 30 days after receipt of the claim form. Such an extension of time may not exceed 15 additional days and notice of the extension shall be provided to the claimant prior to the termination of the initial 30 day period indicating the special circumstances requiring the extension and the date by which a final decision on the claim is expected.

To decide the Plan's liability, the Dental Claims Administrator may require additional information, including, but not limited to:

(a) itemized bills,

(b) proof of benefits from other sources,

(c) proof that the claimant has applied for all benefits from other sources, and that the claimant has furnished any proof required to get them,

(d) a complete dental charting indicating extractions, missing teeth, fillings, prosthesis, periodontal pocket depths, orthodontic relationship and the dates work was previously performed, and

(e) preoperative x-rays, study models, laboratory and/or hospital reports.

To Whom Payable

If the Participant or covered dependent assigns dental benefits to the provider of the dental treatment, any benefits payable under the Plan will be paid directly to the provider. Otherwise, any benefits payable under the Plan will be paid to the Participant. After the Participant's death, the Dental Claims Administrator has the option to pay any benefits payable under the Plan to the Participant's spouse; to the providers of the treatment; or to the Participant's estate.

Claim Denials

In the event any claim for benefits is denied, in whole or in part, the Dental Claims Administrator shall notify the claimant of such denial in writing and shall advise the claimant of the Plan's review and appeal procedure. The notice shall be written in a manner calculated to be understood by the claimant and shall

contain:

(a) specific reasons for the denial;

(b) specific references to the Plan provisions on which the denial is based;

(c) a description of any information or material necessary for the claimant to perfect the claim;

(d) an explanation of why such information or material is necessary; and

(e) an explanation of the Plan's review and appeal procedure.

Discretion of Plan Administrator

The discretionary responsibility and authority to determine eligibility for participation in the Plan and to interpret Plan provisions and to determine whether a claim will be paid or denied rests solely with the Plan Administrator.

Appeal Procedure

If a claim is denied in whole or in part as recommended by the Dental Claims Administrator the following claims appeal procedure shall be observed:

(a) The claimant, or the claimant's duly authorized representative, may appeal the denial by submitting to the Plan Administrator or the Dental Claims Administrator a written request for review of the claim within 180 days after receiving written notice of such denial from the Dental Claims Administrator. Failure by the claimant to submit a request for review within 180 days after receiving the denial of benefits shall constitute a waiver by the claimant of the right to appeal the decision. The Plan Administrator or the Dental Claims Administrator shall, upon the claimant's request, give the claimant an opportunity to review relevant documents, other than legally privileged documents, in preparing such request for review.

(b) The request for review must be in writing and shall be addressed as follows:

Sun Life Financial
P.O. Box 2940
Clinton, IA 52733-2940

(c) The request for review shall set forth all of the grounds upon which it is based, all facts in support thereof and any other matters which the claimant deems pertinent. The Plan Administrator or the Dental Claims Administrator may require the claimant to submit, at the expense of the claimant, such additional facts, documents or other material as are necessary or advisable in conducting the review.

(d) The Dental Claims Administrator shall act upon each request for review within 60 days after the Dental Claim Administrator receives the request for review.

(e) In the event the Plan Administrator confirms the denial of the claim for benefits in whole or in part, written notice of the Plan Administrator's decision shall be given to the claimant. Such notice shall be written in a manner calculated to be understood by the claimant and shall contain the specific reasons for the denial.

Exhaustion of Administrative Remedies

No legal action for benefits under the Plan shall be brought unless and until the following has occurred:

(a) The claimant has submitted a proper written claim for benefits;

(b) The claimant has been notified by the Dental Claims Administrator that the claim is denied.

(c) The claimant has filed a written appeal with the Plan Administrator or the Dental Claims Administrator for review of the denied claim as recommended by the Dental Claims Administrator.

(d) The claimant has been notified in writing of the Plan Administrator's decision to uphold the denial or the Plan Administrator has failed to take any action on the request for review within the time prescribed by the terms of the Plan.

Required Physician Examination

The Dental Claims Administrator may require the claimant to submit to a medical examination, to be paid for by the Plan, by a doctor or dentist selected by the Dental Claims Administrator upon submission of a claim for benefits under the Plan.

General Right to Receive and Release Necessary Information

Subject to state law requirements, the Dental Claims Administrator may, for the purpose of determining a claimant's qualification for an amount of benefits, and without the specific consent of any person, release to, or obtain from, any person, any information with respect to any person which the Dental Claims Administrator reasonably deems to be necessary for such purpose. Any employee shall furnish such information as the Dental Claims Administrator reasonably deems to be necessary to administer the Plan.

Overpayment

If a benefit is paid under the Plan and it is later shown that a lesser amount should have been paid, the Plan will be entitled to a refund of the excess amount from the provider or the Participant.

Subrogation Rights

In the event of any payments for benefits provided to the Participant or a covered dependent under the Plan, the Plan or Plan Administrator ("Subrogor"), as the case may be, to the extent of the Plan's payments, will be subrogated to all rights of recovery the Participant or a covered dependent has against any person or organization. The Participant or covered dependent will execute and deliver any instruments and papers as may be required and do whatever else is necessary to secure those rights to the Subrogor and will do nothing after loss to prejudice the Subrogor's rights. If the Subrogor is precluded from exercising the Subrogation Rights, the Subrogor may exercise the Right to Reimbursement.

Right to Reimbursement

If the Participant or a covered dependent: (a) seeks legal recourse (whether by suit, settlement, judgment or otherwise) against any person or organization; and (b) recovers payment, in whole or in part, from any such person or organization for the benefits previously paid under the Plan, then the Participant or covered dependent must reimburse the Plan for all payments made under the Plan for which reimbursement was received.

Any payments made prior to determination of work-related injury, will be reimbursed upon determination of such payment.

However, the reimbursement will not exceed: (a) the amount of the benefit payments made under the Plan for which payment is recovered from any person or organization; or (b) the amount recovered from any such person or organization as payment for the same covered dental expenses.

The Participant or covered dependents are not obligated by this provision to seek legal action against any person or organization for which benefits have been paid under the Plan.

ARTICLE NINE

CONTRIBUTIONS AND THE FUND

Actuarial Determinations and Methods

From time to time the Plan Administrator shall determine the amount of total contributions necessary to fund the liabilities and expenses of the Plan for the relevant time period. In establishing the liabilities and the contributions under the Plan, such methods and assumptions as will reasonably reflect the cost of the benefits will be utilized.

Participating Employer Contributions

From time to time, the Adopting Employer and certain Participating Employers, as determined by the Plan Administrator, may contribute to the Plan Administrator, Dental Claims Administrator or any Trust Fund an amount determined by the Plan Administrator to be necessary to provide the benefits under the Plan determined by the application of accepted actuarial methods and assumptions. The method of funding shall be consistent with the Plan objectives. From time to time, the Adopting Employer and certain Participating Employers, as determined by the Plan Administrator, shall contribute to the Plan Administrator, Dental Claims Administrator or any Trust Fund an amount determined by the Plan Administrator to be necessary to provide for the expenses necessarily incurred to establish and maintain the Plan.

Employee Contributions

From time to time, each Participant of certain Employers shall contribute to any Trust Fund such amounts as may be required under the Plan in accordance with a uniform, nondiscriminatory procedure established by the Plan Administrator.

Trust Fund

As part of the Plan, a Trust Fund may be created by the Adopting Employer under which the Trustee or Trustees receives any designated contributions of Participants and Employers and holds, invests and distributes the Fund in accordance with the terms and provisions thereof. All expenses incident to administering the Trust shall be paid out of the Fund.

Source of Benefits

If a Trust Fund is created under the above section, all benefits under the Plan shall be provided solely from the Fund, and neither the Plan Administrator, Plan Sponsor, Adopting Employer, or the Participating Employers or either their officers, directors or stockholders shall have any liability or responsibility therefor. Neither the Plan Administrator, Plan Sponsor, Adopting Employer, nor the Participating Employers, shall be liable in any manner should the Fund be insufficient to provide for the payment of any benefit under the Plan.

ARTICLE TEN

ADMINISTRATION

Plan Sponsor

The Plan Sponsor is identified in Article One: ERISA Information.

Plan Administrator

The Plan Administrator is identified in Article One: ERISA Information.

Powers, Duties and Responsibilities of Plan Administrator

The primary responsibility of the Plan Administrator is to administer the Plan for the exclusive benefit of the Participants and their covered dependents, subject to the specific terms of the Plan. The Plan Administrator shall administer the Plan in accordance with its terms and shall have the power to determine all questions arising in connection with the administration, interpretation, and application of the Plan. Any such determination by the Plan Administrator may correct any defect, supply any information, or reconcile any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of this Plan; provided, however, that any interpretation or construction shall be done in a nondiscriminatory manner and shall be consistent with the intent that the Plan shall comply with the terms of ERISA and all regulations issued pursuant thereto. The Plan Administrator shall have all discretionary authority to accomplish his duties under this Plan.

The Plan Administrator shall be charged with the duties of the general administration of the Plan, including, but not limited to, the following:

(1) to determine all questions relating to the eligibility of employees to participate or continue participation hereunder;

(2) to maintain all necessary records for the administration of the Plan;

(3) to interpret the provisions of the Plan and to make such rules for regulation of the Plan as are consistent with hereof;

(4) to determine the size and type of any contract to be purchased from any insurer, and to designate the insurer from which such contract shall be purchased;

(5) to direct the computation and certification from time to time of the sums of money necessary or desirable to be contributed to any Trust Fund;

(6) to assist any Participant regarding his rights, benefits or elections available under the Plan;

(7) to communicate to employees, Participants and their covered dependents a summary plan description outlining the provisions of the Plan as required under Title I of ERISA;

(8) to review and decide appeals by claimants from the denial of benefits as recommended by the Dental Claims Administrator;

(9) to appoint or employ one or more persons to assist in the administration of the Plan or to render advice with regard to any of its responsibilities under the Plan;

(10) to prescribe procedures to be followed by employees making claims for benefits; and

(11) to request from Employers, Participants and employees such information as shall be

necessary for proper administration of the Plan.

Reliance Upon Information

In making decisions under the Plan, the Plan Administrator shall be entitled to rely upon information furnished by an employee, Employers, Participants, Dental Claims Administrator, counsel, doctor or dentist.

Records and Reports

The Plan Administrator shall keep a record of all actions taken and shall keep all other books of account, record, and other data that may be necessary for proper administration of the Plan and shall be responsible for supplying all information and reports to the Internal Revenue Service, Department of Labor, Participant, and others as required by law.

Information From Participating Employers

To enable the Plan Administrator to perform its functions, Employers shall supply full and timely information to the Plan Administrator on all matters as the Plan Administrator may require. The Plan Administrator may rely upon such information as is supplied by Employers and shall have no duty or responsibility to verify such information.

ARTICLE ELEVEN

AMENDMENT AND TERMINATION OF THE PLAN

Amendment and Termination of the Plan

The Adopting Employer intends for the Plan to continue indefinitely; however, the Adopting Employer reserves the right to alter, amend or terminate this Plan at any time, for any reason, in whole or in part, provided that no amendment shall authorize or permit any part of any Trust Fund to be used or diverted to any purpose other than to the exclusive benefit of the Participants. Notwithstanding the foregoing, this Plan may be amended at any time to conform its provisions to the requirements of ERISA, the Internal Revenue Code, Treasury Regulations or rulings thereunder.

Final Distribution Upon Plan Termination

As provided in the section above, the Adopting Employer shall have the right to terminate this Plan at any time for any reason. Upon a complete termination, no part of any Trust Fund shall be used or diverted to any purpose other than to the exclusive benefit of the Participants, unless otherwise permitted by law.

ARTICLE TWELVE

MISCELLANEOUS

Gender and Number

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

Uniformity

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner.

No Guaranty of Employment

The Plan does not constitute a contract between an Employer and any employee and is not a consideration for, or an inducement for, the employment of any employee by an Employer. Nothing contained in the Plan shall be deemed to give any employee the right to be retained in the services of an Employer or to interfere with the Employer's right to terminate the employment of an employee at any time without regard to the effect the termination may have on such employee's participation in the Plan.

Headings Not to Control

Headings and titles within the Plan are for convenience only and are not to be read as part of the text of the Plan.

Separability of Plan Provisions

If any provisions of the Plan are declared invalid or not enforceable for any reason, such provisions will not affect the remaining terms and conditions which shall be construed and enforced thereafter as if such invalid or unenforceable provisions had not been inserted.

Applicable Law

The validity and effect of the Plan and the rights and obligations of all persons affected thereby, are to be construed and determined in accordance with applicable federal law, and to the extent that federal law is inapplicable, under the laws of the State of Pennsylvania.

Entire Plan

This document is a complete statement of the Plan and as of the effective date listed on the Execution Page supersedes all prior plans, proposals, representations, promises and inducements, written or oral, relating to its subject matter. The Employers shall not be bound by or liable to any person for any representation, promise or inducement made by any person which is not embodied in this document or in any authorized written amendment to the Plan.

STATEMENT OF ERISA RIGHTS

As a Participant in (name of plan) you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group dental coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights.

The Plan Administrator is Phoebe – Devitt Homes 1925 Turner Street, Allentown, PA 18104 PH: 610-794-5176. The Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of the Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or

(2) Your employment ends for any reason other than your gross misconduct.

Your dependent spouse will become a qualified beneficiary if your dependent spouse loses coverage under the Plan because any of the following qualifying events happens:

(1) You die;

(2) Your hours of employment are reduced;

(3) Your employment ends for any reason other than gross misconduct; or

(4) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

(1) You die;

(2) Your hours of employment are reduced;

(3) Your employment ends for any reason other than gross misconduct;

(4) You become divorced or legally separated; or

(5) The child stops being eligible for coverage under the Plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, the Employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to: Phoebe – Devitt Homes.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to: Phoebe – Devitt Homes.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, your spouse and dependent children can receive additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to your spouse and dependent children if you die or you get divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying

event. This notice must be sent to: Phoebe-Devitt Homes.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact Phoebe – Devitt Homes or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is an order from a court or administrative agency that enforces the medical child support obligations of a non-custodial parent. A National Medical Support Notice (NMSN) issued by a state agency if properly completed is accepted as a QMCSO.

To qualify as a QMCSO the order must clearly specify certain information as follows:

(a) The name and address of the Participant (the employee) and the name and address of the alternate recipient (any child of the Participant who is recognized under the Order as having a right to enrollment) or the alternate recipient's designee.
(b) Type of coverage to be provided.
(c) Period to which the Order applies.

If the Order requires any type or form of benefit or any option not otherwise provided under the Plan, then such Order shall not qualify as a QMCSO. If the Order is deemed to meet the requirements to qualify as a QMCSO and the Participant has waived coverage or is enrolled in a different level of coverage (for example single coverage) the Plan Administrator is required to enroll the Participant and qualified alternate recipient in the appropriate Plan; applicable premiums associated with the level of coverage will be withheld from the Participant's paycheck.

A complete description of what qualifies as a QMSCO along with the procedures that must be followed by the Plan Administrator and the submitting entity is available from your Plan Administrator. Orders being submitted for consideration should be directed to the Plan Administrator.

COMPLIANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

Use and Disclosure of Protected Health Information

Notwithstanding any provision in this Plan to the contrary, the Plan will use and disclose Protected Health Information (PHI) only to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations (45 C.F.R. Part 160-164). Specifically, the Plan will use and disclose PHI for purposes related to dental care treatment, payment for dental care, and/or dental care operations.

Special Definitions

Individually Identifiable Health Information: health information that is created or received by the Plan or the Employer which relates to the past, present or future physical or mental health or condition of an individual or the past, present or future provision of health/dental care to an individual, and which identifies (or provides a reasonable basis for identifying) such individual.

Plan Administration Functions: administration of functions performed by the Employer on behalf of the Plan and excludes functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.

Protected Health Information: Individually Identifiable Health Information except as specifically excluded from this definition, that is (i) transmitted by electronic media; (ii) maintained in any medium described in the definition of electronic media at 45 C.F.R. 162.103; or (iii) transmitted or maintained in any other form or medium. Protected Health Information excludes Individually Identifiable Health Information in (i) education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) employment records held by a covered entity in its role as Employer.

Treatment: the provision, coordination, or management of dental care and related services by one or more dental care providers, including the coordination or management of dental care by a dental provider with a third party; consultation between dental care providers relating to a patient; or the referral of a patient for health or dental care from one dental care provider to another.

Certification by the Employer

Neither the Plan, nor any dental insurance issuer to business associate servicing the Plan shall disclose a Participant's PHI to the Employer unless the Employer certifies that the Plan has been amended to incorporate HIPAA's privacy provisions and agrees to abide by such privacy provisions.

Employer Covenants

The Employer agrees to:

(a) not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(b) ensure that any agents, including subcontractors, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(c) not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

(d) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by the individual with respect to whom the PHI relates;

(e) report to the Plan any use or disclosure of PHI of which it becomes aware that is not permitted under the Plan's privacy policies and procedures or the HIPAA privacy regulations;

(f) make PHI available to an individual in accordance with HIPAA's access requirements;

(g) make PHI available for amendment by an individual and incorporate any amendments to PHI in accordance with HIPAA;
(h) make available the information required to provide an accounting of disclosures;
(i) make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
(j) if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

Adequate Separation Between the Plan and the Employer Must Be Maintained

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

(a) The Privacy Officer;
(b) Staff designated by the Privacy Officer.

Limitations of Protected Health Information Access and Disclosure

The employees and class of employees identified in the above paragraph may only have access to and use and disclose PHI for Plan Administration Functions that the Employer performs for the Plan.

Noncompliance Mechanism

The employees or class of employees identified above will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer, for any use or disclosure of PHI and breach or violation of or noncompliance with the provisions of this section. The Employer will promptly report such breach, violation or noncompliance to the Plan as required above and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance on any person, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.