

MetLife

YOUR SUMMARY PLAN DESCRIPTION

City of Miami Beach

Classic PDP Plan

Dental Benefits for You and Your Dependents

Effective January 1, 2010

YOUR SUMMARY PLAN DESCRIPTION

INTRODUCTION

This Summary Plan Description describes the benefits available to you under the benefits plan of City of Miami Beach. Please read this booklet carefully to become familiar with your benefits. This plan is effective as of January 1, 2011.

This is a self-funded Dental Benefits Plan provided by the Employer. Metropolitan Life Insurance Company ("MetLife") does not insure the benefits described in this booklet.

Claims are administered on behalf of This Plan by MetLife as the Claim Administrator pursuant to the terms of an administrative service agreement.

Please note that the terms "You" and "Your" throughout this booklet refer to the employee, except where otherwise indicated. Many of the terms that are important in understanding your benefits are explained in the DEFINITIONS section.

City of Miami Beach

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BENEFITS AT A GLANCE

This section provides You and Your Dependents with a description of Your benefits. Certain limitations and exclusions may apply to any benefit or benefit amount. It is important that You and Your Dependents refer to the provisions contained in this Summary Plan Description for details about Your benefits.

BENEFIT

BENEFIT AMOUNT AND HIGHLIGHTS

Dental Benefits For You and Your Dependents

Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Reasonable and Customary Charge
Type A Services	100%	100%
Type B Services	80%	80%
Type C Services	50%	50%
Orthodontic Covered Services	50%	50%
Deductibles for:		
Yearly Individual Deductible	\$50 for the following Covered Services Combined: Type B; Type C	\$50 for the following Covered Services Combined: Type B; Type C
Yearly Family Deductible	\$150 for the following Covered Services Combined: Type B; Type C	\$150 for the following Covered Services Combined: Type B; Type C
Maximum Benefit:		
Yearly Individual Maximum Benefit Amount	\$2,000 for the following Covered Services: Type A; Type B; Type C	\$2,000 for the following Covered Services: Type A; Type B; Type C
Lifetime Individual Maximum Benefit Amount for Orthodontic Covered Services	\$1,500	\$1,500

NOTE: During the first year that You are covered for Dental Benefits, You will only be covered for Type A Services and Type B Services. After the first year of continuous coverage, You will be covered for all Covered Services.

DEFINITIONS

As used in this Summary Plan Description, the terms listed below will have the meanings set forth below. When defined terms are used in this Summary Plan Description, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job on a Full-Time basis. This must be done at:

- the Employer's place of business;
- an alternate place approved by the Employer; or
- a place to which the Employer's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Employer approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Cast Restoration means an inlay, onlay, or crown.

Child means the following:

Your natural or adopted child; Your stepchild who resides with You; or a child who resides with and is fully supported by You; and who, in each case under age 26.

An adopted child includes a child placed in Your physical custody for purpose of adoption. If prior to completion of the legal adoption the child is removed from Your custody, the child's status as an adopted child will end.

If You provide This Plan notice, a Child also includes a child for whom You must provide Dental Benefits due to a Qualified Medical Child Support Order as defined in the United States Employee Retirement Income Security Act of 1974 as amended.

The term does not include any person who:

- is in the military of any country or subdivision of any country; or
- is covered under This Plan as an employee.

Claim Administrator means Metropolitan Life Insurance Company ("MetLife"), New York, New York. The Claim Administrator does not insure the benefits described in this Summary Plan Description.

Contributory Coverage means coverage for which the Employer requires You to pay any part of the cost of coverage.

Contributory Coverage includes: Dental Benefits.

Covered Percentage means:

- for a Covered Service performed by an In-Network Dentist, the percentage of the Maximum Allowed Charge that This Plan will pay for such services after any required Deductible is satisfied; and
- for a Covered Service performed by an Out-of-Network Dentist, the percentage of the Reasonable and Customary Charge that This Plan will pay for such services after any required Deductible is satisfied.

Covered Service means a dental service used to treat Your or Your Dependent's dental condition which is:

- prescribed or performed by a Dentist while such person is covered for Dental Benefits;
- Dentally Necessary to treat the condition; and
- described in the section entitled BENEFITS AT A GLANCE or DENTAL BENEFITS sections of this Summary Plan Description.

DEFINITIONS (continued)

Deductible means the amount You or Your Dependents must pay before This Plan will pay for Covered Services.

Dental Hygienist means a person trained to:

- remove calcareous deposits and stains from the surfaces of teeth; and
- provide information on the prevention of oral disease.

The term does not include:

- You;
- Your Spouse or registered Domestic Partner; or
- any member of Your immediate family including Your and/or Your Spouse's:
 - parents;
 - children (natural, step or adopted);
 - siblings;
 - grandparents; or
 - grandchildren.

Dentally Necessary means that a dental service or treatment is performed in accordance with generally accepted dental standards, as determined by the Claim Administrator, and is:

- necessary to treat decay, disease or injury of the teeth; or
- essential for the care of the teeth and supporting tissues of the teeth.

Dentist means:

- a person licensed to practice dentistry in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Dentist's services for purposes of This Plan. Each such person must be licensed in the jurisdiction where the services are performed and must act within the scope of that license. The person must also be certified and/or registered if required by such jurisdiction.

For purposes of Dental Benefits, the term will include a Physician who performs a Covered Service.

Dentures means fixed partial dentures (bridgework), removable partial dentures and removable full dentures.

Dependent(s) means Your Spouse, Registered Domestic Partner and/or Child.

Employer means City of Miami Beach.

Full-Time means Active Work of at least 30 hours per week on the Employer's regular work schedule for the eligible class of employees to which You belong.

In-Network Dentist means a Dentist who participates in the Preferred Dentist Program and has a contractual agreement with MetLife to accept the Maximum Allowed Charge as payment in full for a dental service.

Maximum Allowed Charge means the lesser of:

- the amount charged by the Dentist; or
- the maximum amount which the In-Network Dentist has agreed with MetLife to accept as payment in full for the dental service.

DEFINITIONS (continued)

Out-of-Network Dentist means a Dentist who does not participate in the Preferred Dentist Program.

Physician means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the group benefits. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction.

The term does not include:

- You;
- Your Spouse or domestic partner; or
- any member of Your immediate family including Your and/or Your Spouse's:
 - parents;
 - children (natural, step or adopted);
 - siblings;
 - grandparents; or
 - grandchildren.

Proof means Written evidence satisfactory to the Claim Administrator that a person has satisfied the conditions and requirements for any benefit described in this Summary Plan Description. When a claim is made for any benefit described in this Summary Plan Description, Proof must establish:

- the nature and extent of the loss or condition;
- This Plan's obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

Reasonable and Customary Charge is the lowest of:

- the Dentist's actual charge for the services or supplies (or, if the provider of the service or supplies is not a Dentist, such other provider's actual charge for the services or supplies) (the 'Actual Charge'); or
- the usual charge by the Dentist or other provider of the services or supplies for the same or similar services or supplies (the 'Usual Charge'); or
- the usual charge of other Dentists or other providers in the same geographic area equal to the 90th percentile of charges as determined by the Claim Administrator based on charge information for the same or similar services or supplies maintained in the Claim Administrator's Reasonable and Customary Charge records (the 'Customary Charge'). Where the Claim Administrator determines that there is inadequate charge information maintained in the Claim Administrator's Reasonable and Customary Charge records for the geographic area in question, the Customary Charge will be determined based on actuarially sound principles.

An example of how the 90th percentile is calculated is to assume one hundred (100) charges for the same service are contained in the Claim Administrator's Reasonable and Customary charge records. These one hundred (100) charges would be sorted from lowest to highest charged amount and numbered 1 through 100. The 90th percentile of charges is the charge that is equal to the charge numbered 90.

DEFINITIONS (continued)

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to the Claim Administrator, and consistent with applicable law.

Spouse means Your lawful spouse.

The term does not include any person who:

- is in the military of any country or subdivision of any country; or
- is covered under This Plan as an employee.

This Plan means the self-funded Dental Benefits plan of the Employer.

Written or Writing means a record which is on or transmitted by paper or electronic media which is acceptable to the Claim Administrator and consistent with applicable law.

Year or Yearly, for Dental Benefits, means the 12 month period that begins January 1.

You and Your mean an employee who is eligible for the benefits described in this Summary Plan Description.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOU

ELIGIBLE CLASS(ES)

All Full-Time employees of the Employer.

You are eligible for coverage if You were Actively at Work and covered for coverage on the day immediately preceding the date of Your retirement and have retired in accord with the Employer's retirement plan. Please be aware that:

- references to Active Work and Actively at Work will not apply; and
- end of employment will mean the end of the person's status as a retiree, as stated in the Employer's retirement plan.

DATE YOU ARE ELIGIBLE FOR COVERAGE

You may only become eligible for the coverage available for Your eligible class as shown in the section entitled BENEFITS AT A GLANCE.

You will be eligible for coverage described in this Summary Plan Description on the later of:

1. January 1, 2010; and
2. the day after the date You complete the Waiting Period of 31 days.

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for coverage. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

ENROLLMENT PROCESS

If You are eligible for coverage, You may enroll for such coverage by completing the required form in Writing. If You enroll for Contributory Coverage, You must also give the Employer Written permission to deduct contributions from Your pay for such coverage. You will be notified by the Employer how much You will be required to contribute.

The Dental Benefits have a regular enrollment period established by the Employer. Subject to the rules of This Plan, You may enroll for Dental Benefits only when You are first eligible, during an annual enrollment period or if You have a Qualifying Event. You should contact the Employer for more information regarding the flexible benefits plan.

DATE YOUR COVERAGE TAKES EFFECT

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for benefits, for the first year, You will only be covered for Type A Services and Type B Services, provided You are Actively at Work on that date. After the first year, You will be covered for all Covered Services, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the coverage would otherwise take effect, the coverage will take effect on the day You resume Active Work.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOU (continued)

If You Do Not Enroll When First Eligible

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for coverage until the next enrollment period for Dental Benefits, as determined by the Employer, following the date You first become eligible. At that time You will be able to enroll for coverage for which You are then eligible.

Enrollment During An Annual Enrollment Period

During any annual enrollment period as determined by the Employer, You may enroll for coverage for which You are eligible or choose a different option than the one for which You are currently enrolled. If You are not currently enrolled for Dental Coverage but You enroll during an enrollment period, the Dental coverage takes effect one year after Your request. Otherwise the changes to Your coverage made during an enrollment period will take effect on the first day of the month following the enrollment period, if You are Actively at Work on that date. For the first year, You will only be covered for Type A Services and Type B Services. After the first year of continuous coverage, You will be covered for all Covered Services, provided You are Actively at Work on the date.

If You are not Actively at Work on the date the coverage would otherwise take effect, coverage will take effect on the date You resume Active Work.

Enrollment Due to a Qualifying Event

You may enroll for coverage, for which You are eligible, or change the amount of Your coverage between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The coverage enrolled for, or changes to Your coverage made as a result of a Qualifying Event, will take effect on the first day of the month following the date of Your request, if You are Actively at Work on that date. For the first year, You will only be covered for Type A Services and Type B Services, provided You are Actively at Work on that date. After the first year, You will be covered for all Covered Services, provided You are Actively at Work on the date.

If You are not Actively at Work on the date the coverage would otherwise take effect, coverage will take effect on the day You resume Active Work.

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage; or
- You previously did not enroll for Dental Benefits for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
 1. loss of eligibility for the other group coverage;
 2. termination of employer contributions for the other group coverage; or
 3. COBRA Continuation of the other group coverage was exhausted.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOU (continued)

DATE YOUR COVERAGE ENDS

Your coverage will end on the earliest of:

1. the date This Plan ends;
2. the date coverage ends for Your class;
3. the end of the period for which the last contribution has been paid for You;
4. the last day of the calendar month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF COVERAGE; or
5. the last day of the calendar month in which You retire in accordance with the Employer's retirement plan.

In certain cases, coverage may be continued as stated in the section entitled CONTINUATION OF COVERAGE.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT COVERAGE

All Full-Time employees of the Employer.

DATE YOU ARE ELIGIBLE FOR DEPENDENT COVERAGE

You may only become eligible for the Dependent coverage available for Your eligible class as shown in the section entitled BENEFITS AT A GLANCE.

You will be eligible for Dependent coverage described in this Summary Plan Description on the latest of:

1. January 1, 2010;
2. the date You enter a class eligible for coverage;
3. the date You obtain a Dependent; and
4. the day after the date You complete the Waiting Period of 31 days.

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for coverage. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

No person may be covered as a Dependent of more than one employee.

ENROLLMENT PROCESS

If You are eligible for Dependent coverage, You may enroll for such coverage by completing the required form in Writing for each Dependent to be covered. If You enroll for Contributory Coverage, You must also give the Employer Written permission to deduct contributions from Your pay for such coverage. You will be notified by the Employer how much You will be required to contribute.

In order to enroll for Dental Coverage for Your Dependents, You must either (a) already be enrolled for Dental Benefits for You or (b) enroll at the same time for Dental Benefits for You.

The Dental Benefits have a regular enrollment period established by the Employer. Subject to the rules of This Plan, You may enroll for Dependent coverage only when You are first eligible, during an enrollment period or if You have a Qualifying Event. You should contact the Employer for more information regarding the flexible benefits plan.

DATE COVERAGE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for Dependent coverage, for the first year, You will only be covered for Type A Services and Type B Services, provided You are Actively at Work on that date. After the first year, You will be covered for all Covered Services, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the coverage would otherwise take effect, the coverage will take effect on the day You resume Active Work.

If You Do Not Enroll When First Eligible

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for Dependent coverage until the next enrollment period for Dental Benefits, as determined by the Employer, following the date You first become eligible. At that time You will be able to enroll for coverage for which You are then eligible.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOUR DEPENDENTS (continued)

Enrollment During An Annual Open Enrollment Period

During any annual open enrollment period as determined by the Employer, You may enroll for Dependent coverage for which You are eligible or choose a different option than the one for which Your Dependents are currently enrolled. If You are not currently enrolled for Dependent coverage but You enroll during an enrollment period, the Dependent coverage takes effect the first day of the year after Your request. Otherwise the changes to Your Dependent coverage made during an enrollment period will take effect on the date of your qualifying event, if You are Actively at Work on that date. For the first year You will only be covered for Type A Services and Type B Services. After the first year of continuous coverage, You will be covered for all Covered Services. Such benefits will take effect on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the coverage would otherwise take effect, coverage will take effect on the date You resume Active Work.

Enrollment Due to a Qualifying Event

You may enroll for Dependent coverage for which You are eligible, or change the amount of Your Dependent coverage, between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The coverage enrolled for, or changes to Your coverage made as a result of a Qualifying Event, will take effect on the date of your qualifying event, if You are Actively at Work on that date. For the first year, You will only be covered for Type A Services and Type B Services, provided You are Actively at Work on that date. After the first year, You will be covered for all Covered Services, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the coverage would otherwise take effect, coverage will take effect on the day You resume Active Work.

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage; or
- You previously did not enroll for Dental Coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
 1. loss of eligibility for the other group coverage;
 2. termination of employer contributions for the other group coverage;
 3. COBRA Continuation of the other group coverage was exhausted.

Once You have enrolled one Child for Dependent Coverage, each succeeding Child will automatically be covered for such coverage on the date the Child qualifies as a Dependent.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOUR DEPENDENTS (continued)

DATE YOUR COVERAGE FOR YOUR DEPENDENTS ENDS

A Dependent's coverage will end on the earliest of:

1. the date You die;
2. the date Dental Benefits for You ends;
3. the date This Plan ends;
4. the date coverage for Your Dependents ends under This Plan;
5. the date coverage for Your Dependents ends for Your class;
6. the last day of the calendar month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF COVERAGE;
7. the end of the period for which the last contribution has been paid;
8. the last day of the calendar month in which the person ceases to be a Dependent, except that for Utah residents the coverage on a Child will cease at the end of the month in which that person ceases to be a Dependent; or
9. the last day of the calendar month in which You retire in accordance with the Employer's retirement plan.

In certain cases, coverage may be continued as stated in the section entitled CONTINUATION OF COVERAGE.

CONTINUATION OF COVERAGE

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Coverage for a Dependent Child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to This Plan within 31 days after the date the Child attains the age limit and at reasonable intervals after such date.

Subject to the DATE COVERAGE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: COVERAGE FOR YOUR DEPENDENTS, coverage will continue while such Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap; and
- continues to qualify as a Child, except for the age limit.

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify for continuation of coverage under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Employer for information regarding such legally mandated leave of absence laws.

COBRA CONTINUATION FOR DENTAL BENEFITS

If Dental Benefits for You or a Dependent ends, You or Your Dependent may qualify for continuation of such coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). Please refer to the COBRA section of this Summary Plan Description entitled NOTICE OF YOUR RIGHT AND YOUR DEPENDENT'S RIGHT TO CONTINUE DENTAL BENEFITS or contact the Employer for information regarding continuation of coverage under COBRA.

DENTAL BENEFITS

If You or a Dependent incur a charge for a Covered Service, Proof of such service must be sent to the Claim Administrator. When the Claim Administrator receives such Proof, the Claim Administrator will review the claim and if the Claim Administrator approves it, This Plan will pay the Dental Benefits in effect on the date that service was completed.

These Dental Benefits give You access to Dentists through the MetLife Preferred Dentist Program (PDP). Dentists participating in the PDP have agreed to limit their charge for a dental service to the Maximum Allowed Charge for such service. Under the PDP, This Plan pays benefits for Covered Services performed by either In-Network Dentists or Out-of-Network Dentists. However, You may be able to reduce Your out-of-pocket costs by using an In-Network Dentist because Out-of-Network Dentists have not entered into an agreement with MetLife to limit their charges. You are always free to receive services from any Dentist. You do not need any authorization from This Plan to choose a Dentist.

The PDP does not provide dental services. Whether or not benefits are available for a particular service, does not mean You should or should not receive the service. You and Your Dentist have the right and are responsible at all times for choosing the course of treatment and services to be performed. After services have been performed, the Claim Administrator will determine the extent to which benefits, if any, are payable.

When requesting a Covered Service from an In-Network Dentist, it is recommended that You:

- identify Yourself as covered in the Preferred Dentist Program; and
- confirm that the Dentist is currently an In-Network Dentist at the time that the Covered Service is performed.

The amount of the benefit will not be affected by whether or not You identify Yourself as a member in the Preferred Dentist Program.

You can obtain a customized listing of MetLife's In-Network Dentists either by calling 1-800-942-0854 or by visiting MetLife's website at www.metlife.com/dental.

BENEFIT AMOUNTS

This Plan will pay benefits in an amount equal to the Covered Percentage for charges incurred by You or a Dependent for a Covered Service as shown in the section entitled BENEFITS AT A GLANCE, subject to the conditions set forth in this Summary Plan Description.

In-Network

If a Covered Service is performed by an In-Network Dentist, This Plan will base the benefit on the Covered Percentage of the Maximum Allowed Charge.

If an In-Network Dentist performs a Covered Service, You will be responsible for paying:

- the Deductible; and
- any other part of the Maximum Allowed Charge for which This Plan does not pay benefits.

Out-of-Network

If a Covered Service is performed by an Out-of-Network Dentist, This Plan will base the benefit on the Covered Percentage of the Reasonable and Customary Charge.

Out-of-Network Dentists may charge You more than the Reasonable and Customary Charge. If an Out-of-Network Dentist performs a Covered Service, You will be responsible for paying:

- the Deductible;
- any other part of the Reasonable and Customary Charge for which This Plan does not pay benefits; and
- any amount in excess of the Reasonable and Customary Charge charged by the Out-of-Network Dentist.

DENTAL BENEFITS (continued)

Maximum Benefit Amounts

The section entitled BENEFITS AT A GLANCE sets forth Maximum Benefit Amounts This Plan will pay for Covered Services received In-Network and Out-of-Network.

Deductibles

The Deductible amounts are shown in the section entitled BENEFITS AT A GLANCE.

The Yearly Individual Deductible is the amount that You and each Dependent must pay for Covered Services to which such Deductible applies each Year before This Plan will pay benefits for such Covered Services.

This Plan applies amounts used to satisfy Yearly Individual Deductibles to the Yearly Family Deductible. Once the Yearly Family Deductible is satisfied, no further Yearly Individual Deductibles are required to be met.

The amount This Plan applies toward satisfaction of a Deductible for a Covered Service is the amount the Claim Administrator uses to determine benefits for such service.

Alternate Benefit

If the Claim Administrator determines that a service, less costly than the Covered Service the Dentist performed, could have been performed to treat a dental condition, This Plan will pay benefits based upon the less costly service if such service:

- would produce a professionally acceptable result under generally accepted dental standards; and
- would qualify as a Covered Service.

For example:

- when an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, the Claim Administrator may base the benefit determination upon the amalgam filling which is the less costly service;
- when a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, the Claim Administrator may base the benefit determination upon the filling which is the less costly service;
- when a filling and a crown are both professionally acceptable methods for treating tooth decay or breakdown, the Claim Administrator may base the benefit determination upon the filling which is the less costly service; and
- when a partial denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch, the Claim Administrator may base the benefit determination upon the partial denture which is the less costly service.

If This Plan pays benefits based upon a less costly service in accordance with this subsection, the Dentist may charge You or Your Dependent for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an In-Network Dentist.

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this Summary Plan Description, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, This Plan will only pay benefits for the root canal therapy.

DENTAL BENEFITS (continued)

Orthodontic Covered Services

Orthodontic treatment generally consists of initial placement of an appliance and periodic follow-up visits.

The benefit payable for the initial placement will not exceed 20% of the Maximum Benefit Amount for Orthodontia.

The benefit payable for the periodic follow-up visits will be payable on a quarterly basis during the course of the orthodontic treatment if:

- Dental Benefits are in effect for the person receiving the orthodontic treatment; and
- Proof is given to the Claim Administrator that the orthodontic treatment is continuing.

Benefits for Orthodontic Services Begun Prior to these Dental Benefits

If the initial placement was made prior to these Dental Benefits being in effect, the benefit payable will be reduced by the portion attributable to the initial placement.

If the periodic follow-up visits commenced prior to these Dental Benefits being in effect:

- the number of months for which benefits are payable will be reduced by the number of months of treatment performed before these Dental Benefits were in effect; and
- the total amount of the benefit payable for the periodic visits will be reduced proportionately.

Pretreatment Estimate of Benefits

If a planned dental service is expected to cost more than \$200, You have the option of requesting a pretreatment estimate of benefits. The Dentist should submit a claim detailing the services to be performed and the amount to be charged. After the Claim Administrator receives this information, the Claim Administrator will provide You with an estimate of the Dental Benefits available for the service. The estimate is not a guarantee of the amount This Plan will pay. Under the Alternate Benefit provision, benefits may be based on the cost of a service other than the service that You choose. You are required to submit Proof on or after the date the dental service is completed in order for This Plan to pay a benefit for such service.

The pretreatment estimate of benefits is only an estimate of benefits available for proposed dental services. You are not required to obtain a pretreatment estimate of benefits. As always, You or Your Dependent and the Dentist are responsible for choosing the services to be performed.

DENTAL BENEFITS (continued)

Benefits This Plan Will Pay After Coverage Ends

This Plan will pay benefits for a 31 day period after Your coverage ends for the completion of installation of a prosthetic device if:

- the Dentist prepared the abutment teeth or made impressions before Your coverage ends; and
- the device is installed within 31 days after the date the coverage ends.

This Plan will pay benefits for a 31 day period after Your coverage ends for the completion of installation of a Cast Restoration if:

- the Dentist prepared the tooth for the Cast Restoration before Your coverage ends; and
- the Cast Restoration is installed within 31 days after the date the coverage ends.

This Plan will pay benefits for a 31 day period after Your coverage ends for completion of root canal therapy if:

- the Dentist opened into the pulp chamber before Your coverage ends; and
- the treatment is finished within 31 days after the date the coverage ends.

DENTAL BENEFITS: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams and problem-focused exams but no more than one exam every 6 months.
2. Full mouth or panoramic x-rays once every 3 Years.
3. Bitewing x-rays 1 set every 12 months.
4. Intraoral-periapical x-rays.
5. X-rays, except as mentioned elsewhere.
6. Pulp vitality and bacteriological studies for determination of bacteriologic agents.
7. Diagnostic casts.
8. Cleaning of teeth (oral prophylaxis) once every 6 months.
9. Topical fluoride treatment for a Child under age 16, once in 12 months.

Type B Covered Services

1. Initial placement of amalgam fillings.
2. Replacement of an existing amalgam filling, but only if:
 - at least 24 months have passed since the existing filling was placed; or
 - a new surface of decay is identified on that tooth.
3. Initial placement of resin-based composite fillings.
4. Replacement of an existing resin-based composite filling, but only if:
 - at least 24 months have passed since the existing filling was placed; or
 - a new surface of decay is identified on that tooth.
5. Consultations, but not more than once in a 12 month period.
6. Periodontal scaling and root planing, but not more than once per quadrant in any 24 month period.
7. Simple extractions.
8. Space maintainers for a Child under age 16.
9. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 3 years.
10. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.
11. Occlusal adjustments.
12. Sealants for a Child under age 16 which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 3 years.

DENTAL BENEFITS: DESCRIPTION OF COVERED SERVICES (continued)

Type C Covered Services

1. Emergency palliative treatment to relieve tooth pain.
2. Biopsies of hard or soft oral tissue.
3. Pulp capping (excluding final restoration).
4. Therapeutic pulpotomy (excluding final restoration).
5. Pulp therapy.
6. Apexification/recalcification.
7. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when the Claim Administrator determines such anesthesia is necessary in accordance with generally accepted dental standards.
8. Injections of therapeutic drugs.
9. Initial installation of full or partial Dentures (other than implant supported prosthetics):
 - when needed to replace congenitally missing teeth; or
 - when needed to replace natural teeth that are lost while the person receiving such benefits was covered for Dental Benefits under this Summary Plan Description.
10. Addition of teeth to a partial removable Denture to replace natural teeth removed while these Dental Benefits were in effect for the person receiving such services.
11. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 5 years prior to replacement.
12. Replacement of a non-serviceable removable Denture if such Denture was installed more than 5 years prior to replacement.
13. Replacement of an immediate, temporary, full Denture with a permanent, full Denture, if the immediate, temporary, full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full Denture.
14. Relinings and rebasings of existing removable Dentures:
 - if at least 6 months have passed since the installation of the existing removable Denture; and
 - not more than once in any 36 month period.
15. Re-cementing of Cast Restorations or Dentures, but not more than once in a 12 month period.
16. Initial installation of Cast Restorations.
17. Replacement of any Cast Restoration with the same or a different type of Cast Restoration, but no more than one replacement for the same tooth surface within 5 years of a prior replacement.
18. Prefabricated stainless steel crown or prefabricated resin crown, but no more than one replacement for the same tooth surface within 5 years.
19. Core buildup, but no more than once per tooth in a period of 5 years.
20. Posts and cores, but no more than once per tooth in a period of 5 years.
21. Oral Surgery, except as mentioned elsewhere in this Summary Plan Description.
22. Root canal treatment, but not more than once in any 24 month period for the same tooth.
23. Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
24. Surgical extractions.
25. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), when needed to replace congenitally missing teeth or to replace natural teeth that are lost while the person receiving such benefit was covered for Dental Benefits under this Summary Plan Description, but no more than once for the same tooth position in a 60 month period.
26. Repair of implants, but not more than once in a 12 month period.

DENTAL BENEFITS: DESCRIPTION OF COVERED SERVICES (continued)

27. Tissue conditioning, but not more than once in a 36 month period.
28. Simple repair of Cast Restorations or Dentures other than recementing, but not more than once in a 12 month period.
29. Cone Beam Imaging, not more than once for the same tooth position in 5 years.
30. Full mouth debridements, but not more than once in any 24 month period.
31. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to two times in any Year less the number of teeth cleanings received during such Year.
32. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture.

Orthodontic Covered Services

Orthodontia for Your eligible, dependent child up to age 26.

DENTAL BENEFITS: EXCLUSIONS

This Plan will not pay Dental Benefits for charges incurred for:

1. services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which This Plan deems experimental in nature;
2. services for which You would not be required to pay in the absence of Dental Benefits;
3. services or supplies received by You or Your Dependent before the Dental Benefits start for that person;
4. services which are neither performed nor prescribed by a Dentist, except for those services of a licensed dental hygienist which are supervised and billed by a Dentist, and which are for:
 - scaling and polishing of teeth; or
 - fluoride treatments;
5. services which are primarily cosmetic;
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
8. restorations or appliances used for the purpose of periodontal splinting;
9. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
10. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss;
11. initial installation of a Denture to replace one or more teeth which were missing before such person was covered for Dental Benefits, except for congenitally missing teeth;
12. decoration or inscription of any tooth, device, appliance, crown or other dental work;
13. missed appointments;
14. services:
 - covered under any workers' compensation or occupational disease law;
 - covered under any employer liability law;
 - for which the Employer of the person receiving such services is not required to pay; or
 - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
15. services covered under other coverage provided by the Employer;
16. temporary or provisional restorations;
17. temporary or provisional appliances;
18. prescription drugs;
19. services for which the submitted documentation indicates a poor prognosis;
20. the following, when charged by the Dentist on a separate basis:
 - claim form completion;
 - infection control, such as gloves, masks, and sterilization of supplies; or
 - local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide;
21. dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
22. caries susceptibility tests;
23. protective (sedative) fillings;
24. labial veneers;
25. local chemotherapeutic agents;
26. modification of removable prosthodontic and other removable prosthetic services;
27. fixed and removable appliances for correction of harmful habits;

DENTAL BENEFITS: EXCLUSIONS (continued)

28. appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
29. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
30. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
31. duplicate prosthetic devices or appliances;
32. replacement of a lost or stolen appliance, Cast Restoration or Denture;
33. repair or replacement of an orthodontic device;
34. diagnosis and treatment of temporomandibular joint disorders;
35. intra and extraoral photographic images.

DENTAL BENEFITS: COORDINATION OF BENEFITS

When You or a Dependent incur charges for Covered Services, there may be other Plans, as defined below, that also provide benefits for those same charges. In that case, This Plan may reduce what This Plan pays based on what the other Plans pay. This Coordination of Benefits section explains how and when This Plan does this.

DEFINITIONS

In this section, the terms set forth below have the following meanings:

Allowable Expense means a necessary dental expense for which both of the following are true:

- a covered person must pay it; and
- it is at least partly covered by one or more of the Plans that provide benefits to the covered person.

If a Plan provides fixed benefits for specified events or conditions (instead of benefits based on expenses incurred), such benefits are Allowable Expenses.

If a Plan provides benefits in the form of services, This Plan treats the reasonable cash value of each service performed as both an Allowable Expense and a benefit paid by that Plan.

The term does not include:

- expenses for services performed because of a Job-Related Injury or Sickness;
- any amount of expenses in excess of the higher reasonable and customary fee for a service, if two or more Plans compute their benefit payments on the basis of reasonable and customary fees;
- any amount of expenses in excess of the higher negotiated fee for a service, if two or more Plans compute their benefit payments on the basis of negotiated fees; and
- any amount of benefits that a Primary Plan does not pay because the covered person fails to comply with the Primary Plan's managed care or utilization review provisions, these include provisions requiring:
 - second surgical opinions;
 - pre-certification of services;
 - use of providers in a Plan's network of providers; or
 - any other similar provisions.

This Plan won't use this provision to refuse to pay benefits because an HMO member has elected to have dental services provided by a non-HMO provider and the HMO's contract does not require the HMO to pay for providing those services.

Claim Determination Period means a period that starts on any January 1 and ends on the next December 31. A Claim Determination Period for any covered person will not include periods of time during which that person is not covered under This Plan.

Custodial Parent means a Parent awarded custody, other than joint custody, by a court decree. In the absence of a court decree, it means the Parent with whom the child resides more than half of the Year without regard to any temporary visitation.

HMO means a Health Maintenance Organization or Dental Health Maintenance Organization.

Job-Related Injury or Sickness means any injury or sickness:

- for which You are entitled to benefits under a workers' compensation or similar law, or any arrangement that provides for similar compensation; or
- arising out of employment for wage or profit.

DENTAL BENEFITS: COORDINATION OF BENEFITS (continued)

Parent means a person who covers a child as a dependent under a Plan.

Plan means any of the following, if it provides benefits or services for an Allowable Expense:

- a group insurance plan;
- an HMO;
- a blanket plan;
- uninsured arrangements of group or group type coverage;
- a group practice plan;
- a group service plan;
- a group prepayment plan;
- any other plan that covers people as a group;
- motor vehicle No Fault coverage, if the coverage is required by law; and
- any other coverage required or provided by any law or any governmental program, except Medicaid.

The term does not include any of the following:

- individual or family insurance or subscriber contracts;
- individual or family coverage through closed panel Plans or other prepayment, group practice or individual practice Plans;
- hospital indemnity coverage;
- a school blanket plan that only provides accident-type coverage on a 24 hour basis, or a "to and from school basis," to students in a grammar school, high school or college;
- disability income protection coverage;
- -accident only coverage;
- specified disease or specified accident coverage;
- nursing home or long term care coverage; or
- any government program or coverage if, by state or Federal law, its benefits are excess to those of any private insurance plan or other non-government plan.

The provisions of This Plan, which limit benefits based on benefits or services provided under:

- Government Plans; or
- Plans which the Employer (or an affiliate) contributes to or sponsors;

will not be affected by these Coordination of Benefits provisions.

Each policy, contract or other arrangement for benefits is a separate Plan. If part of a Plan reserves the right to reduce what it pays based on benefits or services provided by other Plans, that part will be treated separately from any parts which do not.

This Plan means the Dental Benefits described in this Summary Plan Description, except for any provisions in this Summary Plan Description that limit coverage based on benefits for services provided under government plans, or plans which the Employer (or an affiliate) contributes to or sponsors.

Primary Plan means a Plan that pays its benefits first under the "Rules to Decide Which Plan Is Primary" section. A Primary Plan pays benefits as if the Secondary Plans do not exist.

DENTAL BENEFITS: COORDINATION OF BENEFITS (continued)

Secondary Plan means a Plan that is not a Primary Plan. A Secondary Plan may reduce its benefits by amounts payable by the Primary Plan. If there are more than two Plans that provide coverage, a Plan may be Primary to some plans, and Secondary to others.

RULES TO DECIDE WHICH PLAN IS PRIMARY

When more than one Plan covers the person for whom Allowable Expenses were incurred, the Claim Administrator determines which plan is primary by applying the rules in this section.

When there is a basis for claim under This Plan and another Plan, This Plan is Secondary unless:

- the other Plan has rules coordinating its benefits with those of This Plan; and
- this Plan is primary under This Plan's rules.

The first rule below, which will allow the Claim Administrator to determine which Plan is Primary, is the rule that the Claim Administrator will use.

Dependent or Non-Dependent: A Plan that covers a person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is Primary and shall pay its benefits before a Plan that covers the person as a dependent; except that if the person is a Medicare beneficiary and, as a result of federal law or regulations, Medicare is:

- Secondary to the Plan covering the person as a dependent; and
- Primary to the Plan covering the person as other than a dependent (e.g., a retired employee);

then the order of benefits between the two Plans is reversed and the Plan that covers the person as a dependent is Primary.

Child Covered Under More Than One Plan – Court Decree: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, and the specific terms of a court decree state that one of the Parents must provide health coverage or pay for the Child's health care expenses, that Parent's Plan is Primary, if the Plan has actual knowledge of those terms. This rule applies to Claim Determination Periods that start after the Plan is given notice of the court decree.

Child Covered Under More Than One Plan – The Birthday Rule: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, the Primary Plan is the Plan of the Parent whose birthday falls earlier in the Year if:

- the Parents are married; or
- the Parents are not separated (whether or not they have ever married); or
- a court decree awards joint custody without specifying which Parent must provide health coverage.

If both Parents have the same birthday, the Plan that covered either of the Parents longer is the Primary Plan.

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

DENTAL BENEFITS: COORDINATION OF BENEFITS (continued)

Child Covered Under More than One Plan – Custodial Parent: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, if the Parents are not married, or are separated (whether or not they ever married), or are divorced, the Primary Plan is:

- the Plan of the Custodial Parent; then
- the Plan of the spouse of the Custodial Parent; then
- the Plan of the non-custodial Parent; and then
- the Plan of the spouse of the non-custodial Parent.

Active or Inactive Employee: A Plan that covers a person as an employee who is neither laid off nor retired is Primary to a Plan that covers the person as a laid-off or retired employee (or as that person's Dependent). If the other Plan does not have this rule and, if as a result, the Plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage: The Plan that covers a person as an active employee, member or subscriber (or as that employee's Dependent) is Primary to a Plan that covers that person under a right of continuation pursuant to federal law (e.g., COBRA) or state law. If the Plan that covers the person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule shall not apply.

Longer/Shorter Time Covered: If none of the above rules determine which Plan is Primary, the Plan that has covered the person for the longer time shall be Primary to a Plan that has covered the person for a shorter time.

No Rules Apply: If none of the above rules determine which Plan is Primary, the Allowable Expenses shall be shared equally between all the Plans. In no event will This Plan pay more than it would if it were Primary.

EFFECT ON BENEFITS OF THIS PLAN

If This Plan is Secondary, when the total Allowable Expenses incurred by a covered person in any Claim Determination Period are less than the sum of:

- the benefits that would be payable under This Plan without applying this Coordination of Benefits provision; and
- the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions;

then This Plan will reduce the benefits that would otherwise be payable under This Plan. The sum of these reduced benefits, plus all benefits payable for such Allowable Expenses under all other Plans, will not exceed the total of the Allowable Expenses. Benefits payable under all other Plans include all benefits that would be payable if the proper claims had been made on time.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

The Claim Administrator needs certain information to apply the Coordination of Benefits rules. The Claim Administrator has the right to decide which facts The Claim Administrator needs. The Claim Administrator may get facts from or give them to any other organization or person. The Claim Administrator does not need to tell, or get the consent of, any person or organization to do this. To obtain all benefits available, a covered person who incurs Allowable Expenses should file a claim under each Plan which covers the person. Each person claiming benefits under This Plan must give the Claim Administrator any facts This Plan needs to pay the claim.

DENTAL BENEFITS: COORDINATION OF BENEFITS (continued)

FACILITY OF PAYMENT

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, This Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes benefits provided in the form of services, in which case This Plan may pay the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount This Plan pays is more than This Plan should have paid under this Coordination of Benefits provision, This Plan may recover the excess from one or more of:

- the person This Plan has paid or for whom This Plan has paid;
- insurance companies; or
- other organizations.

The amount of the payment includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

Assignment

Upon receipt of a Covered Service, You may assign Dental Benefits to the Dentist providing such service.

Dental Benefits: Who This Plan Will Pay

If You assign payment of Dental Benefits to Your or Your Dependent's Dentist, This Plan will pay benefits directly to the Dentist. Otherwise, This Plan will pay Dental Benefits to You.

Conformity with Law

If the terms and provisions of this Summary Plan Description do not conform to any applicable law, this Summary Plan Description shall be interpreted to so conform.

Overpayments

Recovery of Dental Benefit Overpayments

This Plan has the right to recover any amount that the Claim Administrator determines to be an overpayment, whether for services received by You or Your Dependents.

An overpayment occurs if the Claim Administrator determines that:

- the total amount paid by This Plan on a claim for Dental Benefits is more than the total of the benefits due to You under this Summary Plan Description; or
- payment This Plan made should have been made by another group plan.

If such overpayment occurs, You have an obligation to reimburse This Plan.

How This Plan Recovers Overpayments

This Plan may recover the overpayment from You by:

- stopping or reducing any future benefits payable for Dental Benefits;
- demanding an immediate refund of the overpayment from You; and
- taking legal action.

If the overpayment results from This Plan having made a payment to You that should have been made under another group plan, This Plan may recover such overpayment from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT TO CONTINUE DENTAL BENEFITS

When Your employment terminates for any reason other than Your gross misconduct, or if Your hours worked are reduced so that Your coverage terminates, You and Your covered Dependents may continue coverage under This Plan for a period of up to 18 months. In addition, if You should die, become divorced or legally separated, or become eligible for Medicare, Your covered Dependents may continue coverage under This Plan for up to 36 months. Also, Your covered children may continue coverage under This Plan for up to 36 months after they no longer qualify as covered Dependents under the terms of This Plan.

COBRA coverage may be extended if it is determined under the terms of the Social Security Act that You or Your covered Dependent is disabled within 60 days after Your termination of employment or reduction of hours. You and Your covered Dependents may continue Your Dental Coverage under This Plan for an additional 11 months after the expiration of the 18 month period for termination of employment or reduction in hours. During the additional 11 months of coverage, Your cost for that coverage will be approximately 50% higher than it was during the preceding 18 months.

Coverage may also be extended for an additional 18 months if, while receiving 18 months of COBRA coverage, You die, become eligible for Medicare Part A and/or Part B, get divorced or legally separated from the Spouse receiving COBRA, or Your Dependent Child is no longer eligible as a Dependent Child under This Plan. Extension of coverage for the additional 18 months only is available if the second event would have caused Your Dependent to lose coverage under This Plan if the first event not occurred and if proper notice is given to This Plan.

During the continuation period, a Child of Yours that is (1) born; (2) adopted by You; or (3) placed with You for adoption, will be treated as if the Child were a covered Dependent at the time coverage was lost due to an event described above.

This continuation will terminate on the earliest of:

1. the end of the 18, 29 or 36 month continuation period, as the case may be;
2. the date of expiration of the last period for which the required payment was made;
3. the date, after a covered person elects to continue coverage, that the covered person first becomes covered under another group health plan, as long as the new plan does not contain any exclusion or limitation with respect to any preexisting condition on the covered person;
4. the date This Plan is cancelled.

Notice will be given when You or Your covered Dependents become entitled to continue coverage under This Plan. You, or they, will then have at least 60 days to elect to continue coverage. However, You or Your covered Spouse or Your covered Child must notify the Employer within 60 days in the event You receive a determination of disability under the terms of the Social Security Act, You become divorced or legally separated, or when Your Dependent Child no longer qualifies as a covered Dependent under This Plan.

Any person who elects to continue coverage under This Plan must pay the full cost of that coverage (including both the share You now pay and the share Your Employer now pays), plus any additional amounts permitted by law. Your payments for continued coverage must be made on the first day of each month in advance.

It is Your responsibility to keep the Plan Administrator informed of any changes in the addresses of family members. It is recommended that You keep a copy, for Your records, of any notices You send to the Plan Administrator.

For additional information about Your rights and obligations under This Plan and under federal law, You should review this Summary Plan Description or You may contact Your Plan Administrator for further assistance.