

**GROUP INSURANCE CERTIFICATE  
AND  
SUMMARY PLAN DESCRIPTION**

STANDARD INSURANCE COMPANY certifies that you will be insured under the Group Policy described below during the time, in the manner, and for the amounts provided in the Group Policy. Possession of this Certificate does not necessarily mean you are insured.



President

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GROUP POLICY NUMBER	513916
NAME OF POLICYHOLDER	BREMERTON SCHOOL DISTRICT NO. 100 C
TYPE OF COVERAGE	DENTAL INSURANCE
GROUP POLICY EFFECTIVE DATE	July 1, 1984
GROUP POLICY DELIVERED IN	Washington and governed by the laws of that state.

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**IMPORTANT: PLEASE READ THIS**

You are insured only if you meet the requirements of Part 2. BECOMING INSURED AS A MEMBER or of Part 3. BECOMING INSURED AS A DEPENDENT OF A MEMBER. You will remain insured only until your insurance ends, as explained in Parts 4 and 5.

A Group Policy has been issued to the Policyholder. Your coverage under that Group Policy is shown in this Certificate. If your coverage is changed by an amendment to the Group Policy, Standard will provide the Policyholder with a notice for you.

PLEASE READ THIS CERTIFICATE CAREFULLY. This Certificate has a Table of Contents to help you find specific provisions. **Defined terms are printed in all capital letters.**

ERISA REQUIREMENTS: ERISA means the Employee Retirement Income Security Act of 1974. Under ERISA, the Plan Administrator gives you this Summary Plan Description of the employee benefits insured under the group policy. General plan information and a statement of your rights as a plan participant are found at the end of this document.

GDC1082-E (Local#114S.E.I.U.)



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## **Part 1. GENERAL DEFINITIONS**

STANDARD means Standard Insurance Company, Portland, Oregon.

EMPLOYER means Bremerton School District No. 100 C and each subsidiary or affiliate approved in writing by STANDARD.

GROUP POLICY means STANDARD'S group policy number 513916 issued to the POLICYHOLDER.

DENTAL INSURANCE means your dental insurance under the GROUP POLICY.

DENTAL BENEFIT means the dental benefit payable according to the terms of the GROUP POLICY.

COVERED PERSON means a MEMBER insured under the GROUP POLICY or a MEMBER'S DEPENDENT insured under the GROUP POLICY.

INCURRED DATE , with respect to a COVERED DENTAL EXPENSE, means the date the services or supplies are provided to you, except for the following COVERED DENTAL EXPENSES:

Prosthetic Appliances: The INCURRED DATE for the placement or modification of a prosthetic appliance is the date the impression is made.

Restorations: The INCURRED DATE for an inlay, onlay or crown is the date the tooth or teeth are prepared.

Root Canal Therapy: The INCURRED DATE for root canal therapy is the date the pulp chamber is opened.

DENTIST means a licensed doctor of dental medicine (D.M.D.) or a licensed doctor of dental surgery (D.D.S.), other than the spouse, brother, sister, parent, or child of (a) the MEMBER, or (b) the MEMBER'S spouse.

DENTURIST means a person who is licensed to make, fit, and repair dentures.

DENTAL HYGIENIST means a person who is licensed to practice dental hygiene.

REASONABLE AND CUSTOMARY CHARGE, with respect to a COVERED DENTAL EXPENSE, means the lesser of:

- (a) The DENTIST'S usual charge for the same services or supplies in the absence of dental insurance coverage; and
- (b) The charge customarily billed to private patients for the same or similar dental services or supplies by DENTISTS with similar training and experience in the same GEOGRAPHICALLY SIGNIFICANT AREA. GEOGRAPHICALLY SIGNIFICANT AREA means an area which STANDARD determines is large enough to provide a representative base of charges for the same or similar dental services or supplies.

CALENDAR YEAR means the twelve month period beginning on January 1st and ending on December 31st.

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## **Part 2. BECOMING INSURED AS A MEMBER**

To become insured as a MEMBER you must meet each of the following requirements plus the ACTIVE WORK requirement:

1. You must be a MEMBER.
2. You must be eligible for DENTAL INSURANCE.

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**A. DEFINITION OF MEMBER**

You must be a MEMBER. You are a MEMBER if you are all of the following:

1. An active union employee of the EMPLOYER, who is a member in good standing of Local #114 S.E.I.U., other than a temporary or seasonal employee;
2. Regularly scheduled to work at least 20 hours each week; and
3. A citizen or resident of the United States or Canada.

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**B. ELIGIBILITY FOR DENTAL INSURANCE**

You must be eligible for DENTAL INSURANCE. You are eligible for DENTAL INSURANCE as follows:

MEMBERS hired on or before the 10<sup>th</sup> of the month: The first day of the calendar month following the date you become a MEMBER.

MEMBERS hired after the 10<sup>th</sup> of the month: First day of the calendar month following 30 consecutive days as a MEMBER.

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**C. EFFECTIVE DATE OF DENTAL INSURANCE FOR A MEMBER**

Your DENTAL INSURANCE will become effective on the date you become eligible, provided you meet the ACTIVE WORK requirement on that date.

**D. ACTIVE WORK REQUIREMENT**

Your DENTAL INSURANCE will become effective as scheduled only if you are ACTIVELY AT WORK all day on your last regular work day before the scheduled effective date. Otherwise, your DENTAL INSURANCE will become effective on the first day after your next full day of ACTIVE WORK. If you were absent from work because of sickness, accidental bodily injury or pregnancy, your DENTAL INSURANCE will not become effective until after you recover and complete one full day of ACTIVE WORK. Your DENTAL INSURANCE will become effective on your regular day off, a holiday or a paid vacation day if the scheduled effective date falls on that day and you were ACTIVELY AT WORK on your last regular work day before that date.

ACTIVE WORK and ACTIVELY AT WORK mean performing the usual duties of your job at your EMPLOYER'S usual place of business.

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**Part 3. BECOMING INSURED AS A DEPENDENT OF A MEMBER**

To become insured as a DEPENDENT of a MEMBER each of the following requirements must be met:

1. You must be the DEPENDENT of a MEMBER.
2. You must be eligible for DENTAL INSURANCE.
3. The MEMBER must apply for DENTAL INSURANCE on the MEMBER'S DEPENDENTS.

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**A. DEFINITION OF DEPENDENT**

You must be a DEPENDENT of a MEMBER. DEPENDENT means a person who is:

1. SPOUSE DEPENDENT: The MEMBER'S spouse.

2. CHILD DEPENDENT\*: The MEMBER'S unmarried child under 25 years of age. CHILD DEPENDENT includes an unmarried adopted child from the moment of placement in the MEMBER'S care and custody. The MEMBER'S stepchild residing in the MEMBER'S home is considered to be the MEMBER'S child.

\*NOTE: An insured CHILD DEPENDENT who ceases to be a CHILD DEPENDENT may qualify for continued DENTAL INSURANCE as a HANDICAPPED CHILD. See CONTINUED COVERAGE FOR A HANDICAPPED CHILD in Part 5.

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## **B. ELIGIBILITY FOR DENTAL INSURANCE**

You are eligible for DENTAL INSURANCE if you are a DEPENDENT of a MEMBER who is eligible for DENTAL INSURANCE, except as follows:

1. You may not become insured as a DEPENDENT of an eligible MEMBER if you are also eligible for DENTAL INSURANCE as a MEMBER.
2. You may not become insured as a DEPENDENT of an eligible MEMBER if you are a full time member of the armed forces of any country.
3. You may not become insured as a DEPENDENT of an eligible MEMBER unless the MEMBER becomes insured for DENTAL INSURANCE.

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## **C. APPLICATION FOR DENTAL INSURANCE**

The MEMBER must apply for DENTAL INSURANCE on the MEMBER'S eligible DEPENDENTS and agree to make the required contributions to the POLICYHOLDER by signing a completed enrollment card. The POLICYHOLDER determines the amount of the MEMBER'S contribution toward the cost of the DENTAL INSURANCE on the MEMBER'S DEPENDENTS.

## **D. EFFECTIVE DATE OF DENTAL INSURANCE**

If you are an eligible DEPENDENT of the MEMBER, your DENTAL INSURANCE will become effective on the latest of the following dates:

- (1) The date the MEMBER becomes insured for DENTAL INSURANCE.
- (2) The date the MEMBER applies for DENTAL INSURANCE on the MEMBER'S eligible DEPENDENTS.
- (3) The date you become an eligible DEPENDENT of the MEMBER.

Your DENTAL INSURANCE will be subject to the LATE ENROLLMENT PENALTY if:

- (a) The MEMBER was eligible to insure you as the MEMBER'S DEPENDENT under the POLICYHOLDER'S group dental insurance program on or before June 1, 1984, but the MEMBER chose not to insure you; or
- (b) Your DENTAL INSURANCE becomes effective more than 31 days after the later of the following dates:
  - i) The date the MEMBER becomes eligible for DENTAL INSURANCE.
  - ii) The date you become an eligible DEPENDENT of the MEMBER.

However, the LATE ENROLLMENT PENALTY will not apply if your DENTAL INSURANCE under the GROUP POLICY becomes effective within 31 days after your insurance under another employer's dental insurance program ends because you are no longer eligible for coverage under that dental insurance program.

## **E. LATE ENROLLMENT PENALTY**

LATE ENROLLMENT PENALTY means your DENTAL INSURANCE coverage will be limited as follows:

- (a) During the first 12 months after your DENTAL INSURANCE becomes effective you will be covered only for COVERED PREVENTIVE DENTAL EXPENSES.
- (b) During the second 12 months after your DENTAL INSURANCE becomes effective you will be covered only for COVERED PREVENTIVE DENTAL EXPENSES and COVERED BASIC DENTAL EXPENSES.

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## **Part 4. WHEN A MEMBER'S DENTAL INSURANCE ENDS**

If you are an insured MEMBER, your DENTAL INSURANCE under the GROUP POLICY will end automatically on the earliest of the following dates:

- a. The last day of the calendar month in which you cease to be a MEMBER as defined in Part 2.A.
- b. The date you become a full time member of the armed forces of any country.
- c. The date the GROUP POLICY terminates.
- d. The last day of the calendar month in which you cease to be ACTIVELY AT WORK for your EMPLOYER on your regular work days. However, your DENTAL INSURANCE may be continued (unless it ends under items a. through c. above) during the following periods while you are absent from ACTIVE WORK:
  - (1) While you are receiving full salary (including sick pay) from your EMPLOYER, and thereafter until the end of the calendar month in which your full salary ends.
  - (2) While you are unable to be ACTIVELY AT WORK as a result of sickness, accidental bodily injury or pregnancy, but not beyond the last day of the calendar month in which your employment is terminated by you or your EMPLOYER or six calendar months, whichever is earlier.
  - (3) During a leave of absence if continuation of your DENTAL INSURANCE under the GROUP POLICY is required by the federal or state-mandated family or medical leave act or law.
  - (4) During any other leave of absence approved by your EMPLOYER, but not beyond the end of the calendar month after the calendar month in which the leave of absence begins.
  - (5) During a general work stoppage (including a strike or lockout) resulting from a labor dispute between your collective bargaining unit and your EMPLOYER, subject to the terms of the Strike Continuation Provision below.

### **STRIKE CONTINUATION PROVISION:**

You may continue your DENTAL INSURANCE for not more than six months while you are absent from ACTIVE WORK because of a general work stoppage (including a strike or lockout) resulting from a labor dispute between your EMPLOYER and your collective bargaining unit, subject to the following rules:

- 1. Your EMPLOYER will notify you in writing of your rights under this provision immediately when your compensation is suspended or terminated because of a work stoppage. Your EMPLOYER will mail the notice to you at your last address on record with the EMPLOYER.
- 2. You must pay the entire premium for your DENTAL INSURANCE (including the EMPLOYER'S share) to your EMPLOYER on or before each premium due date.

3. STANDARD has the right to change the premium rates during the work stoppage in accordance with the terms of the GROUP POLICY.
4. Your DENTAL INSURANCE during a work stoppage will end on the earliest of the following dates:
  - (a) On any premium due date, if you fail to make the required premium payment to your EMPLOYER on or before that date.
  - (b) On the date when you have been absent from ACTIVE WORK for six months.

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### **Part 5. WHEN A DEPENDENT'S DENTAL INSURANCE ENDS**

If you are an insured DEPENDENT of a MEMBER, your DENTAL INSURANCE under the GROUP POLICY will end automatically on the earliest of the following dates:

- a. The last day of the calendar month in which you cease to be a DEPENDENT as defined in Part 3.
- b. The date you become a full time member of the armed forces of any country.
- c. The date the GROUP POLICY terminates.
- d. On the last day of the last period for which the MEMBER made the required contribution for DENTAL INSURANCE on the MEMBER'S eligible DEPENDENTS.
- e. The date the MEMBER'S DENTAL INSURANCE ends for any reason other than the MEMBER'S death.
- f. On the 60th day after the date of the MEMBER'S death. (See Part 10.D.)

#### **CONTINUED COVERAGE FOR A HANDICAPPED CHILD:**

Your DENTAL INSURANCE will not end solely because you cease to be a CHILD DEPENDENT or a STUDENT DEPENDENT if you or your parent who is the insured MEMBER provide STANDARD with satisfactory written proof that you qualify as a HANDICAPPED CHILD. Such proof must be furnished to STANDARD on STANDARD'S forms within 31 days after the date your DENTAL INSURANCE would otherwise end because you ceased to be a CHILD DEPENDENT or a STUDENT DEPENDENT, and thereafter as required by STANDARD, but not more often than once a year. STANDARD has the right, at its expense, to have you examined at reasonable intervals while you are claiming continued coverage under this provision.

HANDICAPPED CHILD means the unmarried child of an insured MEMBER who, on and after the date the child ceases to be a CHILD DEPENDENT or a STUDENT DEPENDENT, is both:

1. Continuously incapable of self-sustaining employment by reason of mental retardation or physical handicap incurred prior to the date the child ceased to be a CHILD DEPENDENT or a STUDENT DEPENDENT; and
2. Continuously chiefly dependent upon the insured MEMBER for support and maintenance or institutionalized because of mental retardation or physical handicap.

If you are a HANDICAPPED CHILD whose DENTAL INSURANCE is continued under this provision, your DENTAL INSURANCE will end automatically on the earliest of the following dates:

1. The date you cease to be a HANDICAPPED CHILD as defined above.
2. 90 days after the date STANDARD mails you a request for proof that you continue to qualify as a HANDICAPPED CHILD, unless you provide STANDARD with the required proof within that 90 day period.

3. The date your coverage would end under this Part 5 for any reason other than your ceasing to be a CHILD DEPENDENT or a STUDENT DEPENDENT.

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## **Part 6. BECOMING INSURED AGAIN AFTER DENTAL INSURANCE ENDS**

A MEMBER, and the DEPENDENTS of the MEMBER, may become insured again under the GROUP POLICY after DENTAL INSURANCE ends. The general rule is that a MEMBER, and the DEPENDENTS of the MEMBER, may become insured again on the same basis as a new MEMBER and DEPENDENT of the MEMBER, as provided in Parts 2 and 3. However, for purposes of becoming insured again, the following rules will apply:

1. If DENTAL INSURANCE ends because the MEMBER fails to make the required premium contribution, DENTAL INSURANCE for the DEPENDENTS of the MEMBER will be subject to the LATE ENROLLMENT PENALTY explained in Part 3.E.
2. If DENTAL INSURANCE ends because a person insured as a MEMBER ceases to be a MEMBER, the MEMBER and the DEPENDENTS of the MEMBER will be immediately eligible for DENTAL INSURANCE if the person insured as a MEMBER becomes a MEMBER again within 90 days after the DENTAL INSURANCE ends.
3. If DENTAL INSURANCE ends because a person insured as a MEMBER is on a federal or state-mandated family or medical leave of absence, and the person becomes a MEMBER again immediately following the period allowed, the DENTAL INSURANCE of the MEMBER, and the DEPENDENTS of the MEMBER, will be reinstated pursuant to the federal or state-mandated family or medical leave act or law.

The DENTAL INSURANCE of the DEPENDENTS of the MEMBER reinstated under items 2. and 3. above will be subject to the LATE ENROLLMENT PENALTY explained in Part 3.E. if (A) the DENTAL INSURANCE of the DEPENDENTS of the MEMBER was subject to the LATE ENROLLMENT PENALTY during the prior period of DENTAL INSURANCE, or (B) the MEMBER applies for DENTAL INSURANCE on the MEMBER'S eligible DEPENDENTS more than 31 days after becoming eligible for DENTAL INSURANCE again.

For purposes of applying the LATE ENROLLMENT PENALTY only, if the MEMBER and the DEPENDENTS of the MEMBER become insured again within 90 days after DENTAL INSURANCE ends, the two periods of DENTAL INSURANCE will be treated as one period of continuous DENTAL INSURANCE and the period when the DEPENDENTS of the MEMBER were not insured will be ignored. (The same principle will apply if DENTAL INSURANCE ends two or more times and each time the MEMBER and the DEPENDENTS of the MEMBER become insured again within 90 days. The three or more periods of DENTAL INSURANCE will be added together for purposes of the LATE ENROLLMENT PENALTY).

DENTAL INSURANCE which becomes effective again will not be retroactive to the date the DENTAL INSURANCE ended.

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## **Part 7. DENTAL BENEFITS**

Subject to all the terms of the GROUP POLICY, STANDARD will pay a DENTAL BENEFIT for COVERED DENTAL EXPENSES incurred by a COVERED PERSON. The DENTAL BENEFIT is a percentage of the REASONABLE AND CUSTOMARY CHARGE for COVERED DENTAL EXPENSES incurred, subject to a DEDUCTIBLE AMOUNT and a MAXIMUM AMOUNT, as follows:

### **A. PERCENTAGE OF REASONABLE AND CUSTOMARY CHARGE PAYABLE**

COVERED PREVENTIVE DENTAL EXPENSES	100%
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COVERED BASIC DENTAL EXPENSES	80%
COVERED MAJOR DENTAL EXPENSES	50%
COVERED ORTHODONTIC EXPENSES	50%

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**B. DEDUCTIBLE AMOUNT**

There is no DEDUCTIBLE AMOUNT for COVERED PREVENTIVE DENTAL EXPENSES or for COVERED ORTHODONTIC EXPENSES.

The DEDUCTIBLE AMOUNT for COVERED BASIC and MAJOR DENTAL EXPENSES is \$25.00 per CALENDAR YEAR per COVERED PERSON.

The FAMILY MAXIMUM DEDUCTIBLE AMOUNT for COVERED BASIC and MAJOR DENTAL EXPENSES provided to all COVERED PERSONS in one family in one CALENDAR YEAR is three times the DEDUCTIBLE AMOUNT.

The applicable DEDUCTIBLE AMOUNT is satisfied when you incur COVERED BASIC DENTAL EXPENSES and COVERED MAJOR DENTAL EXPENSES during the CALENDAR YEAR equal to the DEDUCTIBLE AMOUNT. However, during the CALENDAR YEAR in which the GROUP POLICY becomes effective, any amount applied during that CALENDAR YEAR toward the satisfaction of the deductible amount under your EMPLOYER'S prior dental insurance plan may be applied to satisfy the DEDUCTIBLE AMOUNT for the same CALENDAR YEAR under the GROUP POLICY.

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**C. MAXIMUM AMOUNT**

The annual MAXIMUM AMOUNT payable for all COVERED PREVENTIVE, BASIC and MAJOR DENTAL EXPENSES incurred in any one CALENDAR YEAR is \$1,500 per COVERED PERSON.

The lifetime MAXIMUM AMOUNT payable per insured DEPENDENT CHILD for COVERED ORTHODONTIC EXPENSES is \$1,000.

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**Part 8. COVERED DENTAL EXPENSES**

Subject to the exclusions and limitations in Part 9, COVERED DENTAL EXPENSES means the REASONABLE AND CUSTOMARY CHARGES you are required to pay for the following services and supplies provided by a DENTIST, a DENTAL HYGIENIST under the supervision of a DENTIST, or a DENTURIST, each operating within the scope of his or her license. No DENTAL BENEFIT will be paid for any dental service or supply which is incomplete or temporary, or which is not on the following list of COVERED DENTAL EXPENSES:

**I. COVERED PREVENTIVE DENTAL EXPENSES**

- A. Prophylaxis (cleaning, scaling, and polishing of teeth), but not more often than once in any five month period.
- B. Routine oral examinations of the mouth and teeth, but not more often than once in any five month period.
- C. Fluoride treatments for a COVERED PERSON under age 16, but not more often than once in any five month period.
- D. Dental X-rays limited to:
  - 1. Full mouth X-rays or panoramic X-rays, but not more often than once in any three year period.

2. Bitewing X-rays, but not more often than once in any five month period.
  3. Periapical X-rays.
  4. Occlusal X-rays, but not more often than once in any two year period.
- E. Bacteriologic cultures and examination of oral tissue excised for biopsy.
- F. Emergency palliative treatment primarily for relief of dental pain, not cure.
- G. Space maintainers designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth). This does not include space maintainers used in orthodontics to create a space between teeth.
- H. Application of sealants limited to:
1. Children 16 years of age or younger.
  2. Posterior teeth only.
  3. One application in any three-year period.

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## II. COVERED BASIC DENTAL EXPENSES

- A. Endodontic treatment of diseases of the tooth, pulp, root, and surrounding tissue, as follows: Root canal therapy, pulpotomy, apicoectomy, and retrograde filling.
- Charges for root canal therapy for which the pulp chamber was opened before the effective date of your DENTAL INSURANCE under the GROUP POLICY are not covered, unless you were insured under the POLICYHOLDER'S group dental insurance program on the date immediately preceding the effective date of your DENTAL INSURANCE under the GROUP POLICY.
- B. Simple extraction of one or more teeth.
- C. Oral surgery, including customary postoperative treatment furnished in connection with oral surgery, as follows:
1. Surgical extraction of one or more teeth, including impacted teeth.
  2. Extraction of the tooth root.
  3. Alveolectomy, alveoplasty, and frenectomy.
  4. Excision of pericoronal gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy.
  5. Reimplantation of a natural tooth or transplantation of a natural tooth.
  6. Excision of a tumor or cyst and incision and drainage of an abscess or cyst.
- D. Basic periodontal services, limited to:
1. Periodontal prophylaxis, but not more often than once in any two and one-half month period.
  2. Root scaling and root planing, but not more often than once per quadrant of the mouth in any five month period.
  3. Occlusal adjustment, but only when performed with a covered periodontal surgery.
- E. Study models, but not more often than once in any three year period.
- F. Crown build-up on non-vital teeth.

- G. Pin retention of fillings.
- H. Fillings (restorations) using amalgam, silicate, acrylic, synthetic porcelain, and composite filling materials to restore teeth broken down by decay or injury.  
  
Restorations of the following surfaces of anterior teeth will be considered single surface restorations: Mesiolingual, distolingual, mesiobuccal, and distobuccal.
- I. Recementing inlays, onlays, and crowns.
- J. Recementing bridges.
- K. Repairs to full and partial dentures and bridges, but not more often than once in any two year period and for an amount not greater than 20% of the cost of replacement. Charges for repairs within one year after the initial placement of the appliance are not covered.
- L. General anesthetics and analgesics, including intravenous sedation, when administered in connection with a covered oral surgery.
- M. Antibiotic injections administered by the treating DENTIST.

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### **III. COVERED MAJOR DENTAL EXPENSES**

- A. Major periodontal treatment of the gums and supporting structures of the teeth, as follows:
  1. Gingivectomy, gingival curettage, and mucogingival surgery.
  2. Osseous surgery including flap entry and closure.
  3. Pedical or free soft tissue grafts.
  4. Periodontal appliances (night guards), but not more often than once in any five year period.
  5. Osseous bone grafts, either single or multiple.

PERIODONTAL SPLINTS (other than provisional splints) are not covered.

PERIODONTAL SPLINT means any appliance designed to retain teeth in position, and includes multiple abutments for fixed bridgework.
- B. Restorative Services and Supplies, as follows:
  1. Gold or porcelain inlays, onlays, and crowns, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling material.  
  
Charges for crowns for the purpose of PERIODONTAL SPLINTING are not covered.  
  
Charges for a gold or porcelain inlay, onlay, or crown for which a tooth was prepared before the effective date of your DENTAL INSURANCE under the GROUP POLICY are not covered, unless you were insured under the POLICYHOLDER'S group dental insurance program on the date immediately preceding the effective date of your DENTAL INSURANCE under the GROUP POLICY.
  2. Replacement of an existing inlay, onlay, or permanent crown, but only if it has been at least five years since the restoration was initially placed or last replaced. However, this limitation will not apply if replacement of an existing inlay, onlay, or permanent crown is made necessary by the extraction of one or more functioning natural teeth while your DENTAL INSURANCE under the GROUP POLICY is in effect.
  3. Stainless Steel Crowns.

4. Post and Core.
- C. Prosthetic Services and Supplies, as follows:
1. Initial placement of full or partial dentures or fixed bridgework (including acid etch metal bridges) but only if the denture or bridgework includes replacement of a functioning natural tooth which is extracted or lost while your dental insurance under the POLICYHOLDER'S group dental insurance program is in effect. This limitation will not apply after your DENTAL INSURANCE under the GROUP POLICY has been continuously in effect for 36 months.
  2. Replacement of permanent full or partial dentures or permanent fixed bridgework which cannot be made serviceable, but only if it has been at least five years since the permanent denture or bridgework was initially placed or last replaced.  
  
Charges for any duplicate prosthetic appliance or charges for the replacement of any lost, missing, or stolen prosthetic appliance are not covered.
  3. Addition of one or more teeth to an existing partial denture, but only if required to replace one or more functioning natural teeth extracted or lost while your dental insurance under the POLICYHOLDER'S group dental insurance program is in effect. This limitation will not apply after your DENTAL INSURANCE under the GROUP POLICY has been continuously in effect for 36 months.
  4. Relining or rebasing of existing removable full or partial dentures, but only if it has been at least one year since the denture was placed, and not more often than once in any two year period.

Charges for any prosthetic appliance or modification of any prosthetic appliance for which the impression was made before the effective date of your DENTAL INSURANCE under the GROUP POLICY are not covered, unless you were insured under the POLICYHOLDER'S group dental insurance program on the date immediately preceding the effective date of your DENTAL INSURANCE under the GROUP POLICY.

#### REPLACEMENT OF TEMPORARY DEVICES:

Replacement of a TEMPORARY DEVICE with a permanent device will be covered. However, the DENTAL BENEFIT payable for the permanent device will be reduced by any amount STANDARD initially paid to place the TEMPORARY DEVICE.

TEMPORARY DEVICE means a restorative or prosthetic device, including a crown, a full or partial denture, or fixed bridgework, that is in place for a period of less than 12 months.

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#### IV. COVERED ORTHODONTIC EXPENSES

Orthodontic treatment to an insured CHILD DEPENDENT who is under age 19 when the first active orthodontic appliance is placed, as follows:

1. Cephalometric film.
2. Removable, fixed or cemented appliance for minor treatment for tooth guidance, including impressions, installation and all adjustments within 6 months of installation.
3. Removable, fixed or cemented appliance for interceptive orthodontic treatment, including impressions, installation and all adjustments within 6 months of installation.
4. Comprehensive (full banded) orthodontic treatment of transitional or permanent dentition, including:
  - a. Initial placement of orthodontic appliance.

b. Subsequent active orthodontic treatment.

DENTAL BENEFITS for COVERED ORTHODONTIC EXPENSES are paid as the charges for the orthodontic treatment are incurred, but not before the date the first active orthodontic appliance is placed. No DENTAL BENEFIT will be paid for charges incurred after the date the CHILD DEPENDENT'S DENTAL INSURANCE ends, even if the orthodontic treatment begins while the CHILD DEPENDENT is insured.

Charges for orthodontic treatment for which the first active orthodontic appliance was installed before the effective date of the CHILD DEPENDENT'S DENTAL INSURANCE under the GROUP POLICY are not covered, except as provided in the following takeover provision.

TAKEOVER PROVISION: If the first active orthodontic appliance for a CHILD DEPENDENT was placed prior to the effective date of the GROUP POLICY, STANDARD will pay DENTAL BENEFITS for ongoing COVERED ORTHODONTIC EXPENSES for the CHILD DEPENDENT incurred after the effective date of the GROUP POLICY, subject to the following rules:

- (1) No DENTAL BENEFIT will be paid unless:
  - (a) The CHILD DEPENDENT was under age 19 when the first active orthodontic appliance was placed; and
  - (b) Dental benefits for the CHILD DEPENDENT'S orthodontic treatment were payable under the POLICYHOLDER'S group dental insurance program immediately prior to the effective date of the GROUP POLICY.
- (2) The lifetime MAXIMUM AMOUNT payable under the GROUP POLICY for COVERED ORTHODONTIC EXPENSES for the CHILD DEPENDENT is the lesser of A and B, reduced by C, where:
  - A = The lifetime maximum amount payable for orthodontic treatment for the CHILD DEPENDENT under the POLICYHOLDER'S group dental insurance program in effect on the date of the placement of the CHILD DEPENDENT'S first active orthodontic appliance.
  - B = The lifetime MAXIMUM AMOUNT shown in Part 7.C. for orthodontic treatment begun with the placement of the first active orthodontic appliance on the effective date of the GROUP POLICY.
  - C = All payments made under the POLICYHOLDER'S group dental insurance program in effect prior to the effective date of the GROUP POLICY for orthodontic treatment for the CHILD DEPENDENT.

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## **Part 9. EXCLUSIONS AND LIMITATIONS**

COVERED DENTAL EXPENSES do not include, and no DENTAL BENEFIT will be paid, for any of the following:

1. Charges for services or supplies other than COVERED DENTAL EXPENSES listed in Part 8, or charges for services or supplies for which no charge would be made in the absence of insurance and for which you are not legally obligated to pay.
2. Charges in excess of the REASONABLE AND CUSTOMARY CHARGE for the services or supplies provided, or which exceed the REASONABLE AND CUSTOMARY CHARGES for the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.
3. Charges for services or supplies which, in STANDARD'S judgement, do not have a reasonably favorable prognosis or which are not necessary according to accepted standards of dental practice.

4. Charges for services or supplies which are not generally accepted by the dental profession and are, in STANDARD'S judgement, experimental or investigational.
5. Charges for services or supplies for which benefits are payable under any medical expense plan.
6. Charges for services or supplies that are primarily for cosmetic purposes.
7. Charges for implants, precision attachments or semi- precision attachments, acid etch (other than acid etch metal bridge retainers), or instruction in dental plaque control or dental hygienics, or nutritional counseling.
8. Charges for appliances or restorations to increase the vertical dimension or to restore the occlusion, or for gnathologic recordings of jaw movements and positions.
9. Charges for services or supplies related to diagnosis or treatment of the temporomandibular joint.
10. Charges for services or supplies for which you are entitled to benefits under any Worker's Compensation Law or employer's liability law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an accidental bodily injury or sickness arising out of or in the course of any employment for wage or profit.
11. Charges for services or supplies received as a result of any dental condition caused or contributed to by war or any act of war. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.
12. Charges resulting from changing from one DENTIST to another while receiving treatment or from receiving care from more than one DENTIST for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one DENTIST had performed all the required dental services.

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## **Part 10. OTHER DENTAL INSURANCE PROVISIONS**

### **A. FREE CHOICE OF DENTIST**

You have the exclusive right to select the DENTIST of your choice to provide you with dental services and supplies.

STANDARD is not responsible for the quality of dental care you receive from the DENTIST you select. STANDARD cannot be held liable for any injuries you suffer while receiving dental services or supplies.

### **B. PREDETERMINATION OF DENTAL BENEFITS AVAILABLE**

PREDETERMINATION means that if your DENTIST submits a TREATMENT PLAN to STANDARD, STANDARD will tell you and your DENTIST how much STANDARD will pay for the dental services and supplies recommended by your DENTIST.

Your DENTIST may submit any TREATMENT PLAN to STANDARD for PREDETERMINATION. STANDARD recommends that your DENTIST submit a TREATMENT PLAN to STANDARD for PREDETERMINATION whenever your DENTIST is recommending dental services and supplies that are expected to result in charges for COVERED DENTAL EXPENSES of \$250.00 or more.

TREATMENT PLAN means the DENTIST'S report which itemizes the dental services and supplies recommended by the DENTIST and shows the DENTIST'S charge for each service or supply. STANDARD may require additional information, if necessary, including supporting preoperative X-rays, study models, and any other appropriate diagnostic materials.

**C. EXTENSION OF BENEFITS PROVISION**

If your DENTAL INSURANCE under the GROUP POLICY ends for any reason other than the termination of the GROUP POLICY, your coverage will be extended to cover the following services and supplies received within the next 30 days, provided that DENTAL BENEFITS would have been paid if your DENTAL INSURANCE under the GROUP POLICY had continued:

1. A fixed partial denture, crown, or onlay, if the tooth or teeth involved are prepared before your DENTAL INSURANCE under the GROUP POLICY ends.
2. An appliance, including modification of the appliance, if the impression is taken before your DENTAL INSURANCE under the GROUP POLICY ends.
3. Root canal therapy, if the pulp chamber is opened before your DENTAL INSURANCE under the GROUP POLICY ends.

**D. CONTINUED COVERAGE FOR DEPENDENTS AFTER DEATH OF INSURED MEMBER**

DENTAL INSURANCE under the GROUP POLICY for an insured DEPENDENT of an insured MEMBER who dies will be continued in force without payment of premiums for 60 days after the death of the insured MEMBER.

This provision will not continue coverage for a DEPENDENT whose DENTAL INSURANCE under the GROUP POLICY would end under Part 5 for any reason other than the death of the insured MEMBER.

**E. COORDINATION OF BENEFITS PROVISION**

This provision applies when an insured MEMBER or an insured DEPENDENT has dental coverage under more than one PLAN.

1. BENEFITS SUBJECT TO THIS PROVISION

ALL DENTAL BENEFITS payable under the GROUP POLICY are subject to this provision.

2. DEFINITIONS FOR THIS PROVISION

a. PLAN, as used in this provision, means the GROUP POLICY and any of the following dental plans providing benefits for dental services or supplies:

- (1) Any group, blanket or franchise insurance policy.
- (2) Any group Blue Cross, group Blue Shield, or group prepayment arrangement.
- (3) Any labor-management trusteeed plan, labor organization, employer organization plan or employee benefit organization plan, whether on an insured or an uninsured basis.
- (4) Any coverage under a governmental plan or any coverage required or provided by law. This does not include a state plan under Medicaid (Title XVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.
- (5) Any other group-type coverage which is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.

Each contract or other arrangement for coverage under (1) through (5) above is a separate PLAN. Also, if an arrangement has two parts and the coordination of benefits rules apply only to one of the two, each of the parts is a separate PLAN.

b. PLAN does not include the following:

- (1) Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through Health Maintenance Organizations or other prepayment service, group practice or individual practice plans.
    - (2) School accident-type coverages covering grammar, high school and college students for accidents only, including athletic injuries, either on a 24-hour or "to and from school" basis.
  - c. ALLOWABLE EXPENSES, as used in this provision, means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the PLANS covering the person for whom claim is made. When a PLAN provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an ALLOWABLE EXPENSE and a benefit paid. Benefits payable under another PLAN will be considered to include benefits that would have been payable had claim been duly made for them.
  - d. CLAIM DETERMINATION PERIOD means a CALENDAR YEAR as defined in Part 1 of the GROUP POLICY. However, a CLAIM DETERMINATION PERIOD does not include any time before or after the period when the MEMBER or DEPENDENT was insured under the GROUP POLICY.
3. To implement this provision it is necessary to determine whether payment must be made first under the GROUP POLICY or first under another PLAN. If payment under the GROUP POLICY must be made first, STANDARD will pay a DENTAL BENEFIT which is not reduced because of this provision. If payment under the other PLAN must be paid first, the payment under the GROUP POLICY will be reduced to the extent necessary to prevent payment of benefits under both PLANS in excess of 100% of the COVERED DENTAL EXPENSE.

If you have coverage under another PLAN in addition to your DENTAL INSURANCE under the GROUP POLICY, STANDARD recommends that you submit your claim to STANDARD and to the other PLAN at the same time. In that way, the proper coordinated benefits may be most quickly determined and paid.

The following rules are applied to determine whether your COVERED DENTAL EXPENSES are paid first under the GROUP POLICY or under the other PLAN:

- a. If the other PLAN does not have a coordination of benefits provision, that other PLAN must provide benefits first.
- b. If the other PLAN also has a coordination of benefits provision, the following rules will apply:
  - (1) The benefits of a PLAN which covers a person as an employee, member or subscriber are determined before those of a PLAN which covers the person as a dependent.
  - (2) If a dependent child is covered by different parents under two separate PLANS, the benefits of the PLAN of the parent whose birthday falls earlier in the calendar year are determined before those of the PLAN of the other parent.

If both parents have the same birthday, the benefits of the PLAN which covered a parent longer are determined before those of the PLAN which covered the other parent. However, if the other PLAN does not have the rule described in the immediately preceding paragraph, 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.

- (3) If a dependent child is covered by divorced or separated parents under two or more PLANS, benefits for that child will be determined in the following order:
  - (a) The PLAN of the parent with custody.
  - (b) The PLAN of the spouse of the parent with custody.
  - (c) The PLAN of the parent not having custody.
- (4) Notwithstanding (1), (2) and (3) above, if the specific terms of a court decree establish a parent's responsibility to provide coverage, and the entity obligated to pay or provide the benefits of the PLAN of that parent has actual knowledge of those terms, the benefits of that PLAN are determined first. This paragraph does not apply with respect to any CLAIM DETERMINATION PERIOD during which benefits are paid or provided before the entity has that actual knowledge.
- (5) The benefits of a PLAN which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a PLAN which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other PLAN does not have this rule and if, as a result, the PLANS do not agree in the order of benefits, this rule will be ignored.
- (6) When the rules set forth in (a) and (b) above do not establish an order of benefit determination, the benefits of a PLAN which has covered a person for a longer period of time will be determined first.

#### 4. EFFECT ON BENEFITS

If all or any part of a COVERED DENTAL EXPENSE for which you claim DENTAL BENEFITS under the GROUP POLICY is an ALLOWABLE EXPENSE under any other PLAN, then DENTAL BENEFITS under the GROUP POLICY will be reduced so that, when they are added to benefits payable under the other PLAN for the same service or supply, the total does not exceed 100% of the COVERED DENTAL EXPENSE.

If DENTAL BENEFITS under the GROUP POLICY are reduced as described above, each benefit will be reduced proportionately and the total amount paid will be charged toward the MAXIMUM AMOUNT in Part 7.C.

However, the amount by which the GROUP POLICY'S benefits have been reduced during the CLAIM DETERMINATION PERIOD will be used by STANDARD to pay ALLOWABLE EXPENSES not otherwise paid which were incurred in the same CLAIM DETERMINATION PERIOD by the insured MEMBER or DEPENDENT for whom the claim is made. As each claim is submitted, STANDARD will determine its obligation to pay for ALLOWABLE EXPENSES based on all claims that have been submitted up to that point in the current CLAIM DETERMINATION PERIOD.

#### 5. RIGHT TO RECEIVE AND RELEASE INFORMATION

For the purpose of determining the applicability of and implementing the terms of this provision, STANDARD may, with such consent from you as may be necessary,

- a. Release any information with respect to your coverage under the GROUP POLICY, and
- b. Obtain from any other insurance, organization, or person any information with respect to your coverage under another PLAN.

You must provide STANDARD with any information necessary to implement this provision.

#### 6. RIGHT OF RECOVERY

If Standard makes a payment to you or to a DENTIST on your behalf and that payment exceeds the maximum amount STANDARD must pay according to the terms of this provision, then STANDARD has the right to recover the payment, to the extent of such excess, from you or the DENTIST who received the payment or from another PLAN to the extent that the payment should have been made by that PLAN.

7. **FACILITY OF PAYMENT**

Whenever payments which should have been made by STANDARD according to the terms of this provision have been made under any other PLAN, then STANDARD has the right to pay the other PLAN any amount necessary in order to satisfy the intent of this provision. Any such payment will be deemed to be a DENTAL BENEFIT paid under the GROUP POLICY, and STANDARD will be fully discharged from liability under the GROUP POLICY, to the extent of such payment.

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## **Part 11. PAYMENT OF CLAIMS**

**A. PAYMENT OF DENTAL BENEFITS**

All DENTAL BENEFITS will be paid directly to the insured MEMBER unless the insured MEMBER provides written authorization for payment to the DENTIST providing the dental services or supplies.

**B. TIME LIMITS FOR FILING A CLAIM**

All DENTAL BENEFITS must be claimed within 90 days after the incurred date of the covered DENTAL EXPENSES or as soon thereafter as reasonably possible and, in any case, within one year after the end of the 90 day period. Claims not filed within these time limits will be denied and no DENTAL BENEFIT will be paid. These time limits will not apply during any period when the claimant lacked the legal capacity to file a claim.

**C. FILING A CLAIM**

All claims for DENTAL BENEFITS should be submitted on STANDARD'S forms. You or your DENTIST should obtain claim forms from the POLICYHOLDER or the Plan Administrator.

You may also request claim forms from STANDARD. If STANDARD fails to provide you with claim forms within 15 days of your request you may submit your claim in a letter stating the COVERED DENTAL EXPENSES for which the claim is made.

**D. PROOF OF COVERED DENTAL EXPENSES**

Proof of each of the following elements of proof of loss must be provided to STANDARD at your expense. No DENTAL BENEFITS will be paid until STANDARD receives satisfactory written proof:

1. That you have incurred COVERED DENTAL EXPENSES, as defined in Part 8.
2. That the dental services and supplies for which DENTAL BENEFITS are claimed are not subject to any exclusion in Part 9.
3. That your DENTAL INSURANCE under the GROUP POLICY was in effect on the INCURRED DATE of the COVERED DENTAL EXPENSES.
4. Of such additional information as STANDARD may reasonably require in connection with your claim for DENTAL BENEFITS.

You must provide your written authorization for STANDARD to obtain the records and information needed to evaluate your eligibility for DENTAL BENEFITS.

**E. INVESTIGATION OF YOUR CLAIM**

STANDARD has the right at any time to conduct an investigation of your claim. No DENTAL BENEFITS will be paid until STANDARD has had a reasonable time to conduct an investigation.

**F. INDEPENDENT DENTAL EXAMINATION**

STANDARD has the right to have a DENTIST of STANDARD'S choice review X-rays and to examine you to evaluate and confirm the services and supplies for which DENTAL BENEFITS are claimed. Any such examination will be conducted at STANDARD'S expense.

STANDARD has the right to defer payment of DENTAL BENEFITS if you or your DENTIST fail to permit or cooperate with a review by the DENTIST of our choice.

**G. RIGHT TO RECOVER BENEFITS PAID BY MISTAKE**

If STANDARD mistakenly makes a payment to you or to a DENTIST on your behalf, and you are not eligible for all or a part of that payment, then STANDARD has the right to recover the payment from you or the DENTIST who received the payment. STANDARD'S right to recover a mistaken payment includes the right to deduct the amount paid by mistake from future DENTAL BENEFITS.

**H. NOTICE OF DECISION ON CLAIM**

You will receive a written decision on your claim within a reasonable period of time after STANDARD receives your claim.

If STANDARD denies all or any part of your claim, you will receive a written notice of denial containing:

- (1) The reasons for the denial;
- (2) Reference to the provisions of the GROUP POLICY on which the denial is based;
- (3) A description of any additional information or documentation you must submit to obtain benefits and an explanation of why such information or documentation is required;
- (4) Notice of your right to a review of the denial; and
- (5) A description of the review procedure.

If you do not receive a written decision on your claim within 90 days after your claim is received, you will have an immediate right to request a review under the review procedure, as if your claim had been denied.

**I. REVIEW PROCEDURE**

You have a right to a review of any denial by STANDARD of all or any part of your claim. To obtain a review, you should send a written request for review to STANDARD within 60 days after you receive notice of the denial. No special form is required.

As a part of your request for review, you may submit issues and comments in writing and provide additional documentation in support of your claim. You may review pertinent documents related to your request for review.

STANDARD will review your claim promptly after receiving your request for review. You will receive written notice of STANDARD'S decision within 60 days after your request for review is received, or within 120 days if special circumstances require an extension. The written decision you will receive will include the reasons for the decision and reference to the provisions of the GROUP POLICY on which the decision is based.

You may authorize another person to act for you under this review procedure.

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## **Part 12. TIME LIMITS ON LEGAL ACTIONS AND CERTAIN DEFENSES**

No action at law or in equity may be brought to recover under the GROUP POLICY until 60 days after written proof of loss has been provided to STANDARD. No such action may be brought more than three years after the time within which proof of loss is required to be furnished.

Any statement you make to obtain DENTAL INSURANCE under the GROUP POLICY will be a representation and not a warranty. No misrepresentation by you will be used to reduce or deny your claim or to deny the validity of your INSURANCE unless:

- (a) Your DENTAL INSURANCE under the GROUP POLICY would not have been approved except for your misrepresentation;
- (b) Your misrepresentation is contained in a written instrument signed by you; and
- (c) You have been given a copy of the written instrument containing your misrepresentation.

After your DENTAL INSURANCE under the GROUP POLICY has been in effect for two years, no misrepresentation by you, except a fraudulent misrepresentation made with actual intent to deceive, will be used to reduce or deny your claim or to deny the validity of your DENTAL INSURANCE under the GROUP POLICY.

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## **Part 13. COBRA CONTINUED COVERAGE**

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) gives QUALIFIED BENEFICIARIES the right to elect COBRA continuation after DENTAL INSURANCE ends because of a QUALIFYING EVENT.

### **A. Definitions For This Section**

QUALIFIED BENEFICIARY means a COVERED PERSON.

A QUALIFYING EVENT occurs when:

1. The MEMBER dies;
2. The MEMBER'S employment terminates for reasons other than gross misconduct as determined by the EMPLOYER;
3. The MEMBER'S work hours fall below the minimum number required to be a MEMBER;
4. The MEMBER becomes divorced or legally separated from a spouse DEPENDENT;
5. The MEMBER becomes entitled to receive Medicare benefits under Title XVIII of the Social Security Act;
6. The child DEPENDENT of a MEMBER ceases to be a DEPENDENT; or
7. The EMPLOYER files a petition for reorganization under Chapter 11 of the U.S. Bankruptcy Code, provided the MEMBER is retired from the EMPLOYER and is insured on the date the petition is filed.

### **B. Electing COBRA Continuation**

Each QUALIFIED BENEFICIARY has the right to elect to continue coverage that was in effect on the day before the QUALIFYING EVENT. The QUALIFIED BENEFICIARY must apply in writing within 60 days of the later of:

1. The date on which DENTAL INSURANCE would otherwise end; and
2. The date on which the EMPLOYER or Plan Administrator gave the QUALIFIED BENEFICIARY notice of the right to COBRA continuation.

### **C. Notice Requirements**

1. When the MEMBER becomes insured, the Plan Administrator must inform the MEMBER and spouse DEPENDENT in writing of the right to COBRA continuation.
2. The QUALIFIED BENEFICIARY must notify the Plan Administrator within 60 days of QUALIFYING EVENT 4 or 6 above.
3. Each QUALIFIED BENEFICIARY who is disabled under Title II or XVI of the Social Security Act at the time of QUALIFYING EVENT 2 or 3 above must notify the Plan Administrator within 60 days after the date disability is determined.
4. The EMPLOYER must give the Plan Administrator written notice within 30 days of QUALIFYING EVENT 1, 2, 3, 5, or 7.
5. Within 14 days of receipt of the EMPLOYER'S notice, the Plan Administrator must notify each QUALIFIED BENEFICIARY in writing of the right to elect COBRA continuation.

### **D. Premium Requirements**

DENTAL INSURANCE continued under this provision will be retroactive to the date DENTAL INSURANCE would have ended because of a QUALIFYING EVENT. The QUALIFIED BENEFICIARY must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the PREMIUM DUE DATE thereafter. See E. COBRA CONTINUATION PERIODS to determine the applicable premium.

### **E. COBRA Continuation Periods**

#### **1. 18-Month COBRA Continuation**

Each QUALIFIED BENEFICIARY may continue DENTAL INSURANCE for up to 18 months after QUALIFYING EVENT 2 or 3 above.

The premium rate for 18-Month COBRA Continuation is 102%.

#### **2. 29-Month COBRA Continuation**

Each QUALIFIED BENEFICIARY who is disabled under Title II or XVI of the Social Security Act at the time of QUALIFYING EVENT 2 or 3 above, may continue coverage for 29 months from the date of the QUALIFYING EVENT.

The premium rate for 29-Month COBRA Continuation is 102% during the first 18 months, 150% during the next 11 months.

#### **3. 36-Month COBRA Continuation**

If you are a DEPENDENT, you may continue DENTAL INSURANCE for up to 36 months after the date of QUALIFYING EVENT 1, 4, 5, or 6.

The premium rate for 36-Month COBRA Continuation is 102%.

Note: The total period of COBRA continuation available in 1 through 3 above will not exceed 36 months.

#### **4. COBRA Continuation For Certain Bankruptcy Proceedings**

If the QUALIFYING EVENT is 7, the COBRA continuation period for a retiree and a retiree's spouse DEPENDENT is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving DEPENDENTS is 36 months from the date of the retiree's death.

The premium rate for COBRA Continuation For Certain Bankruptcy Proceedings is 102%.

### **F. When COBRA Continuation Ends**

COBRA continuation ends on the earliest of:

1. The date the GROUP POLICY terminates;
2. 31 days after the date the last period ends for which a required premium payment was made;
3. The last day of the COBRA continuation period.
4. The date the QUALIFIED BENEFICIARY first becomes entitled to Medicare coverage under Title XVIII of the Social Security Act;
5. The first date on which the QUALIFIED BENEFICIARY is: (a) covered under another group dental policy and (b) not subject to any preexisting condition limitation in that policy.

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## **Part 14. ALLOCATION OF AUTHORITY**

Except for those functions which the GROUP POLICY specifically reserves to the POLICYHOLDER, we have full and exclusive authority to control and manage the GROUP POLICY, to administer claims, and to interpret the GROUP POLICY and resolve all questions arising in the administration, interpretation, and application of the GROUP POLICY.

Our authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested.
2. The right to establish and enforce rules and procedures for the administration of the GROUP POLICY and any claim under it.
3. The right to determine:
  - a. Eligibility for INSURANCE.
  - b. Entitlement to benefits.
  - c. The amount of benefits payable.
  - d. The sufficiency and the amount of information we may reasonably require to determine a., b., or c., above.

Subject to the review procedures of the GROUP POLICY, any decision we make in the exercise of our authority is conclusive and binding.

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