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## GROUP DENTAL 14 INSURANCE CERTIFICATE OF COVERAGE

**Policyholder:** Willamette University

**Policy Number:** OR 301163

**Certificate Effective Date:** April 1, 2016

This is to certify that LifeMap Assurance Company has issued and delivered the Group Dental Insurance Policy to the Policyholder. The Policy insures the Employees of the Policyholder who are eligible for the insurance, become insured, and continue to be insured according to the terms of the Policy. The terms of the Policy that affect your insurance are contained in the following pages. Your coverage may be terminated or modified in whole or in part under the terms and provisions of the Policy.

The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

This Certificate of Coverage describes the benefits that an Enrolled Employee is entitled to receive and becomes a part of the Policy. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This Certificate voids and replaces any prior Certificate issued under the Group Policy Number shown above.

All terms of insurance under the Policy begin and end at 12:01 a.m. Standard time in the place where the Policy is delivered.

Signed for LifeMap Assurance Company at its Home Office in Portland, Oregon.

Chairman, Dudley Slater

President, Beth Andersen

NON-PARTICIPATING

**CERTIFICATE OF COVERAGE  
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## DENTAL COVERAGE OUTLINE

**Eligible Class:** Class 01 - All full-time active Employees working a minimum of 30 hours per week on a regular basis.

Class 02 - All Employees on Severance Agreements who were insured immediately prior to the date of termination;

All Employees on an approved Sabbatical, who were insured immediately prior to the start of the Sabbatical; and

Retirees who were insured immediately prior to the date of retirement.

A Member can only be insured under one Class at any one time.

**Eligibility Waiting Period:** For Class 01 Employees in an eligible class on or before 04/01/2016: None  
For Class 01 Employees entering an eligible class after 04/01/2016: 1 day\*

\*Eligibility Date is the 1<sup>st</sup> of the month following or coinciding with the Employee's completion of the Eligibility Waiting Period. Your Eligibility Date is the first day you are eligible for coverage.

For Employees covered on a current Severance Agreement or on an approved Sabbatical: None\*

\*Waiting Period does not apply, provided it was satisfied as a full-time active Employee prior to the effective date of the severance agreement or sabbatical.

For Retirees, Eligibility Date means the date the Employee retires in accordance with the Policyholder's Retirement Plan. The Employee may enroll for Retiree coverage during the periods shown in Initial Enrollment Period below. If the Employee does not enroll for Retiree coverage or enrollment is made more than 31 days after the date of retirement, coverage ends for the Employee and their Enrolled Dependents on the last day of the month in which they retire.

### **Initial Enrollment Period:**

#### **Active Employees**

You will be entitled to apply for coverage for yourself and your eligible Dependents within the first 31 days of your becoming eligible for coverage according to the eligibility requirements in effect with the Policyholder. Coverage for you and your enrolling eligible Dependents will commence on the Effective Date.

#### **Severance or Sabbatical Employees**

If you applied for coverage as an Active Employee during the period noted above. Your in-force coverage will continue in accordance to your severance agreement or your approved sabbatical period.

#### **Retirees**

You will be entitled to apply for Retiree coverage for yourself and your eligible Dependents:

1. immediately prior to your retirement date; or
2. on your retirement date; or
3. during the 31-day period that follows your retirement date.

Coverage for you and your enrolling eligible Dependents will commence on the Effective Date.

#### **Employee and Retiree Contribution:**

Contributions are determined by Policyholder.

Premiums may be paid by you and/or your Employer for Employee and Dependent coverage.

## BENEFITS SCHEDULE

**Benefit Waiting Period:** None

**Calendar Year Deductible:** \$50 per Member

The Calendar Year Deductible applies individually to each Member before benefits for Class B and Class C Dental Services are paid. The Calendar Year Deductible will be waived for all services covered by this Policy under Class A Dental Services.

**Family Calendar Year Deductible:** \$150 per Family

The Calendar Year Deductible will no longer apply to any Members of a Family once the total amount applied to the per Member Calendar Year Deductibles equals the amount of the Family Calendar Year Deductible shown above.

**Percentage The Policy Pays:**

Class A Dental services: 100%

Class B Dental services: 80%

Class C Dental services: 50%

**Coinsurance:**

After the Calendar Year Deductible is met, we pay a percentage of the Allowed Amount for Covered Services you receive, up to the Calendar Year Maximum. When our payment is less than 100%, you pay the remaining percentage (this is your Coinsurance). The percentage we pay varies, depending on the kind of service or supply you receive and who renders it.

A Participating Dentist will not charge you for any balances for Covered Services beyond your Calendar Year Deductible and/or Coinsurance amount. Nonparticipating Dentists, however, may bill you for any balances over our payment level in addition to any Deductible and/or Coinsurance amount. See the Definitions Section for descriptions of Participating and Nonparticipating Dentists.

You can find a list of Participating Dentists on our website at: [www.LifeMapCo.com](http://www.LifeMapCo.com)

**Calendar Year Maximum:** \$1,500 per Member

**The Calendar Year Maximum** is the maximum amount of benefits we will pay per Member during the Calendar Year.

**Maximum Benefit:**

In addition to the Calendar Year Maximum, benefits for some Covered Services may be limited to a Maximum Benefit. We will provide benefits until the specified Maximum Benefit (which may be either a dollar amount and/or a specified time period) has been reached. Refer to the Dental Benefits section to determine if a Maximum Benefit applies to a Covered Service.

**Credit for Prior Dental Coverage:**

We will credit newly enrolled Members covered under a similar group dental plan immediately prior to becoming enrolled under this Policy with time served toward the Benefit Waiting Periods under this Policy. In order for a credit to be given a Certificate of Creditable Coverage from a prior carrier must be received by us.

## DEFINITIONS

Wherever used in this Policy, the following definitions will apply to the terms listed below. The masculine will include the feminine and the singular will include the plural. Other terms are defined where they are first used.

"**You**" and "**your**" mean the Enrolled Employee. "**We**," "**us**" and "**our**" mean LifeMap Assurance Company.

**Actively at Work or Active Work** means performing the material and substantial duties of your own occupation at the Employer's usual place of business.

**Active Employment** means the Employee is:

1. working for the Employer on a regular and active basis for at least the minimum number of hours stated in the Dental Coverage Outline;
2. receiving regular earnings from the Employer; and
3. employed:
  - a) at the Employer's usual place of business; or
  - b) at a location to which the Employer's business requires the Employee to travel.

**Allowed Amount** means:

1. when services are rendered by a Participating Dentist, the amount Participating Dentists have agreed to accept as full payment for Covered Services; or
2. when services are rendered by a Nonparticipating Dentist, the lesser of:
  - a) the actual billed amount; or
  - b) the Usual and Customary or Reasonable Charge.

Charges in excess of the Allowed Amount by Nonparticipating Dentists are not reimbursable by us. These excess charges are the responsibility of the Member.

**Application** means the document showing the eligible classes, amounts of insurance and other relevant information pertaining to the plan of insurance applied for by the Policyholder. This document is attached to and forms a part of the Policy.

**Benefit Waiting Period** means the continuous length of time the Member must be covered under the Policy before becoming eligible for certain benefits.

**Calendar Year** means the period from January 1 through December 31 each year.

**Certificate** is the description of the benefits for this coverage. The Certificate is part of the Policy between the Employer group and us.

**Covered Services** are those services or supplies, supplies, or treatment listed in the Dental Benefits sections of the Certificate. In order for a dental service to be considered a Covered Service it must be required to prevent, diagnose, or treat diseases or conditions of the teeth and supporting tissues and be considered Dentally Appropriate. These services must be performed by a Dentist or other provider practicing within the scope of their license.

**Deductible or Deductible Amount** means the amount of covered expenses to be incurred by a Member before the benefits of this Policy become payable. This amount is shown on the Benefits Schedule.

**Dentally Appropriate** means a dental service recommended by the treating Dentist or other medical professional, who has personally evaluated the patient, and is determined to be all of the following:

1. appropriate, based upon the symptoms, for determining the diagnosis and management of the condition;
2. appropriate for the diagnosed condition, disease, or Injury;
3. in accordance with recognized national standards of care;
4. could not have been omitted without adversely affecting the Member's condition; and
5. not primarily for the convenience of the Member, Member's family, or provider.

A dental service may be Dentally Appropriate yet not be a Covered Service under the Policy.

**Dentist** means:

1. an individual duly licensed to practice dentistry (including a doctor of medical dentistry or doctor of dental surgery, or a denturist); or
2. a dental hygienist who is permitted, by their respective state licensing board, to independently bill third parties, and
3. who is not the Member or the Spouse, daughter, son, father, mother, sister or brother of the Member.

**Domestic Partner (non-state certified)** means an adult of the same or opposite sex who has an emotional, physical and financial relationship with you, similar to that of a spouse, as evidenced by the following facts:

1. you and your domestic partner share a residence and the financial responsibility for the joint household and intend to continue an exclusive relationship indefinitely;
2. you and your domestic partner each are at least eighteen (18) years of age;
3. you and your domestic partner are both mentally competent to enter into a binding contract;
4. neither you nor your domestic partner are married to or legally separated from anyone else;
5. you and your domestic partner are not related to one another by blood closer than would bar marriage; and
6. neither you nor your domestic partner is a domestic partner of anyone else.

**Effective Date** means the date specified by us, following our acceptance of the application for coverage, as the date coverage begins for you and/or your dependents.

**Eligibility Waiting Period** means the continuous length of time you must be Actively at Work before becoming eligible for coverage under the Policy.

**Employee** means a person who:

1. is in Active Employment with the Employer;
2. is eligible for insurance according to the Dental Coverage Outline;
3. has federal taxes deducted from their earnings and has had FICA deducted, matched and remitted by the Employer;
4. is not a temporary, seasonal or contract Employee; and
5. is a citizen of the United States or legally works in the United States; or
6. is an eligible Retiree;
7. is an Employee no longer employed by the Policyholder, but is on a current Severance agreement; or
8. is an Employee not actively at work, but is on an approved Sabbatical.

**Employer** means the Policyholder and includes any division, subsidiary or affiliated company named in the Application or any Policy amendments.

**Enrolled Dependent** means:

1. an Enrolled Employee's eligible dependent who is listed on the Enrolled Employee's application for coverage;
2. whose application is accepted by us; and
3. who is enrolled under this Policy.

**Enrolled Employee** means an Employee:

1. whose application has been accepted by us; and
2. who is enrolled under this Policy.

**Experimental/Investigational** means a service or supply that we have classified as Experimental/Investigational. In determining whether services are experimental or investigational, we will consider whether the services are in general use in the medical community in the state of Oregon, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious.

**Family** means an Enrolled Employee and their Enrolled Dependents.

**Immediate Family** means parents, Spouse, children, siblings, half-siblings, or in-laws, or any relative by blood or marriage who shares a residence with you.

**Illness** means:

1. a congenital malformation that causes functional impairment;
2. a condition, disease, ailment, or bodily disorder, other than an Injury; and
3. pregnancy.

**Injury** means:

1. physical damage to the body inflicted by a foreign object, force, temperature, or corrosive chemical:  
and
2. that is the direct result of an accident, independent of Illness or any other cause.

Injury does not include:

1. bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing; and
2. does not include any condition related to pregnancy.

**Lifetime** means the entire length of time a Member is covered under the Policy, including any subsequent dental policy issued to the Policyholder by us.

**Member** means an Enrolled Employee or an Enrolled Dependent.

**Nonparticipating Dentist** means a Dentist who does not have an effective participating contract with us to provide services and supplies to Members.

**Participating Dentist** means a Dentist who has an effective participating contract with us to provide services and supplies to Members in accordance with the provisions of the Policy.

**Policy**, when capitalized, means the insurance policy issued and delivered to the Policyholder, including any endorsements, amendments and/or riders.

**Policyholder** means the person, individual firm, trust or other organization named in the Application for the Policy and shown on the face page of this Policy.

**Retiree** means an Employee that was Actively at Work and covered for insurance on the day immediately preceding the date of retirement, who:

1. meets the Policyholder's definition of an eligible retiree; and
2. retired in accordance with the Policyholder's Retirement Plan.

References to Actively at Work and Active Work, and all requirements of Active Employment will not apply. End of employment will mean the end of the person's status as a Retiree as stated in the Policyholder's Retirement Plan.

**Retirement Plan** means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement plan includes but is not limited to any plan which is part of any federal, state, county, municipal or association retirement system.

**Spouse** means the Employee's legal wife, husband, non-state certified or state certified domestic partner.

**Usual and Customary or Reasonable Charge (UCR)** means:

1. **Usual Charge** -- the amount most consistently charged by providers in the same geographic area to patients for a given service; and
2. **Customary Charge** -- a charge which falls within the range of usual charges for a given service billed by most providers in the same geographic area with similar training and experience; or
3. **Reasonable Charge** -- a charge which meets the usual and customary criteria, or which we determine is reasonable in light of the complexity of treatment of the particular case.

The database that LifeMap utilizes to determine the UCR represents benchmarks for 491 various geographic areas in the United States based on localized claim data.

When services are rendered by a Nonparticipating Dentist, the Allowed Amount is based on the 90<sup>th</sup> percentile of the UCR for that geographic area.

A provider may charge more than the Allowed Amount. When you are treated by a Nonparticipating Dentist, you are responsible for any amount charged above the Allowed Amount.

## ELIGIBILITY AND ENROLLMENT

### Employees

You become eligible to apply for coverage on the date you have been Actively at Work for the Policyholder long enough to satisfy any required Eligibility Waiting Period.

### Severance or Sabbatical Employees

If you applied for coverage as an Active Employee as noted above. Your in-force coverage will continue in accordance to your severance agreement or your approved sabbatical period.

### Retirees

You become eligible to apply for Retiree coverage for yourself and your eligible Dependents on or immediately prior to the date you retire, provided you and your eligible Dependents were enrolled for coverage on the day immediately preceding your retirement date.

Note: You must apply for Retiree coverage within the 31-day period following your retirement date.

### Dependents

Your Enrolled Dependents are eligible for coverage when you have listed them on your application or on subsequent change forms and when we have accepted them for coverage under the Policy. Dependents are limited to the following:

1. Your Spouse; or
2. Your or your Spouse's child who is under age 26, unmarried, not in a domestic partnership, and who meets any of the following criteria:
  1. your or your Spouse's natural child, stepchild, adopted child, or child legally placed with you or your Spouse for adoption;
  2. a child for whom you or your Spouse have court-appointed legal guardianship;
  3. a child for whom you or your Spouse are required to provide coverage by a legal qualified medical child support order (QMCSO).

Your or your Spouse's child who is age 26 or over and chiefly dependent upon you or your Spouse for support and maintenance due to developmental disability or physical handicap that began before their 26<sup>th</sup> birthday will continue to be covered if you submit written evidence of the child's incapacity to LifeMap within 31 days of the later of the child's 26<sup>th</sup> birthday or your or your Spouse's Effective Date. After initial certification, proof of disability may be required at reasonable times as LifeMap considers necessary but not more frequently than annually after the two year period following the child's 26<sup>th</sup> birthday.

### Newly Eligible Dependents

You may enroll a dependent who becomes eligible for coverage after your Effective Date by completing and submitting an enrollment request to us. Request for enrollment of a new dependent child by birth, adoption, or placement for adoption must be made within 60 days of the date of birth, adoption, or placement for adoption. Request for enrollment of all other newly eligible dependents must be made within 31 days of the dependent's attaining eligibility.

Coverage for such dependents will commence on their Effective Dates (which, for a new dependent child by birth, adoption, or placement for adoption, is the date of birth, adoption, or placement for adoption, if enrolled within the specified 60 days).

You must promptly furnish any information necessary and appropriate to determining the eligibility of a dependent. Receipt of such information by us will be a condition precedent to enrolling a person as a dependent under the Policy.

Note: If you are a Retiree or an Employee covered by a Severance Agreement, you cannot enroll a newly eligible dependent after your Effective Date.

### **Effective Date of Coverage for Employees in Active Employment**

Subject to the Actively at Work Provision, you and your eligible Dependents will become insured:

1. for Noncontributory Insurance on your eligibility date; or
2. for Contributory Insurance on the later of:
  - a. the effective date of the Policy; or
  - b. the coverage Effective Date assigned by us as follows:
    - i. if you and/or your Dependents enroll within your Initial Enrollment Period, coverage will take effect on the first day of the month following the date you apply for coverage; or
    - ii. if you and/or your Dependents enroll after your Initial Enrollment Period, coverage will take effect on the Effective Date assigned by us.

### **Effective Date of Coverage for Retirees**

You and your eligible Dependents will become insured on the date you retire, provided you enroll for Retiree coverage no later than 31 days after your retirement date.

### **Actively at Work Provision**

Coverage will take effect as scheduled only if you are Actively at Work all day on the last regular working day before the scheduled Effective Date. If you are absent from work due to Illness (including pregnancy or complications of pregnancy) or Injury; coverage will not become effective until the first day after you complete one full day of Active Work.

However, coverage will take effect on your regular day off, a holiday, or a paid vacation day, if the regularly scheduled Effective Date falls on that date and you were Actively at Work on the last regular working day before that date.

### **Annual Enrollment Period**

The Annual Enrollment Period is the period of time to be determined by the Policyholder and us during which you and/or your eligible dependents may enroll for coverage if you and/or your eligible dependents did not enroll when initially eligible. You must submit an application on behalf of all dependents you wish to enroll. Coverage for you and your enrolling eligible dependents will commence on the Effective Date.

Note: If you voluntarily terminate your coverage, you will not have the opportunity to re-enroll during the next two Annual Enrollment Periods following your termination date. The Annual Enrollment Period provision is not applicable to Retirees or Employees under a severance agreement.

## DENTAL BENEFITS

Covered Services are listed below. After any applicable Deductible is met, we pay a portion of the Allowed Amount for Covered Services, up to the Maximum Benefit amount for each Member each Calendar Year as shown in the Benefits Schedule section of the Dental Coverage Outline. You are responsible for paying any applicable coinsurance for Participating Dentists. When treated by a Nonparticipating Dentist, you are responsible for paying any difference between the amount billed and the Allowed Amount. If a Covered Service listed below does not state a specific limitation, services are provided as needed, up to the Calendar Year Maximum.

The Calendar Year Deductible does not apply to Class A Dental Services.

### **Class A Dental Services**

We cover the following Class A dental services:

1. oral examinations, limited to 2 per Member per Calendar Year or up to 3 oral examinations per Calendar Year if the Member has been diagnosed with periodontal disease, diabetes or is pregnant;
2. dental cleanings, including periodontal maintenance, limited to 2 professional cleanings per Member per Calendar Year (whether they are considered cleanings or periodontal maintenance) or up to 3 cleanings or periodontal maintenance procedures per Calendar Year if the Member has been diagnosed with periodontal disease, diabetes or is pregnant;
3. topical fluoride application for Members under 18 years of age, limited to 2 treatments per Member per Calendar Year;
4. intraoral bitewing, occlusal and periapical x-rays, limited to 2 sets per Member per Calendar Year;
5. intraoral complete mouth x-rays, limited to 1 set in a 3 year period;
6. panoramic mouth x-rays, limited to 1 in a 3 year period;
7. sealants, limited to 1 per molar every 5 years for Members under 18 years of age;
8. preventive resin restorations, in lieu of a sealant on a tooth, limited to 1 per molar every 5 years for Members under 18 years of age;
9. space maintainers, limited to 1 per Lifetime per area for Members under 18 years of age.

### **Class B Dental Services**

We cover the following Class B dental services:

1. emergency treatment for pain relief;
2. fillings consisting of composite and amalgam restorations;
3. sedative fillings;
4. general dental anesthesia or intravenous sedation administered in connection with surgical extractions of teeth and to safeguard the Member's health (for example, a child under 7 years of age);
5. oral surgery procedures including:
  - a) simple and surgical extractions of teeth, including impacted teeth;
  - b) biopsies, incision and drainage;
  - c) alveoloplasty;
  - d) vestibuloplasty; and
  - e) residual root removal;

6. periodontal services consisting of:
  - a) full mouth debridement;
  - b) periodontal scaling and root planing, limited to once per Member per quadrant in a 2 year period;
  - c) complex periodontal procedures (including osseous surgery including flap entry and closure, bone replacement grafts and soft tissue graft procedures), limited to once per Member per quadrant in a 5 year period; and
  - d) gingivectomy and gingivoplasty, limited to once per Member per quadrant in a 3 year period; and
7. endodontic services consisting of:
  - a) direct pulp capping;
  - b) pulpal therapy;
  - c) pulpotomy;
  - d) pulpal debridement, limited to 1 tooth in a 2 year period;
  - e) apicoectomy, limited to 1 tooth in a 2 year period; and
  - f) root canal treatment, limited to 1 tooth in a 2 year period.

endodontic benefits will **not** be provided for:

  - a) indirect pulp capping; or
  - b) pulp vitality tests.

### **Class C Dental Services**

We cover the following Class C dental services:

1. prefabricated stainless steel crowns, limited to one prefabricated stainless steel crown, per tooth, in a 5 year period;
2. other crowns, crown build-ups, inlays and onlays, limited to one in a 7 year period, except when:
  - a) any crown, inlay or onlay replacement is made less than 7 years after placement (or subsequent replacement) whether or not originally covered under this Policy; or
  - b) additional procedures are performed to construct a new crown under an existing partial denture framework.
3. re-cement crown, inlay or onlay;
4. repair of crowns, limited to 1 per tooth per Member Lifetime;
5. fixed bridges, limited to 1 per area per Member in a 7 year period;
6. repair of bridges, limited to 1 repair per bridge per Member per Lifetime;
7. dentures, full and partial, limited to 1 per Member per arch in a 7 year period, including:
  - a) denture rebase, limited to 1 per Member per arch in a 3 year period; and
  - b) denture reline, limited to 1 per Member per arch in a 3 year period.

Denture benefits will not be provided for:

  - a) any denture replacement made less than 7 years after denture placement (or subsequent replacement) whether or not originally covered under this Policy;
  - b) interim partial or complete dentures; or
  - c) pediatric dentures.
8. adjustment and repair of dentures, except when the adjustments or repairs are done within 1 year of initial placement, limited to 1 adjustment or repair per Calendar Year; and
9. tissue conditioning, limited to once in a 7 year period.

## EXCLUSIONS

The following are the general exclusions from coverage under the Policy. Other exclusions may apply and, if so, will be described elsewhere in the Policy. No benefits will be provided for any of the following conditions, treatments, services, supplies, or accommodations, **including any direct complications or consequences that arise from them**, as follows:

**Aesthetic Dental Procedures** which includes services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.

**Antimicrobial Agents** including localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.

**Benefits Not Stated.** This means services and supplies that are not identified as benefits under the Policy. When a non-covered service or supply is performed or received at the same time as a Covered Service, only the portion of charges relating to the Covered Service will be considered eligible for payment.

### Collection of Cultures and Specimens

### Connector Bar or Stress Breaker

**Cosmetic/Reconstructive Services and Supplies**, except in the treatment of the following:

1. to treat a congenital anomaly for Members up to age 18; or
2. to restore a physical bodily function lost as result of Injury or Illness.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance and that do not primarily restore an impaired function of the body.

Reconstructive means;

1. services, procedures, and surgery performed on abnormal structures of the body that were caused by congenital defects; or
2. developmental abnormalities, trauma, infection, tumors, or disease.

Reconstructive services are generally performed to restore function, but also may be done to approximate a normal appearance.

For the purposes of this exclusion, psychological factors (for example, poor self-image, difficult social or peer relations) are not relevant and are not considered a physical bodily function.

**Desensitizing** means application of desensitizing medicaments, or desensitizing resin for cervical and/or root surface.

### Diagnostic Casts or Study Models

### Duplicate X-Rays

**Experimental/Investigational** treatments, procedures and services, supplies, and accommodations provided in connection with Experimental/Investigational treatments or procedures. We also exclude any services or supplies provided under an investigational protocol.

**Facility Charges** including services and supplies provided in connection with facility services, including hospitalization for dentistry and extended care facility visits.

**Fees, Taxes, Interest, etc.** including charges for shipping and handling, postage, interest or finance charges that a Dentist might bill. We also do not cover excise, sales, or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state, or local government, or by another entity, unless required by law.

**Fractures of the Mandible**

Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

**Gold Foil Restorations****Home Visits**

**Medication and Supply Charges** including take home drugs, pre-medications, therapeutic drug injections, and supplies.

**Military Service-Related Conditions** which includes services and supplies for treatment of an illness or injury caused by or incurred during service in the armed forces of any state or country.

**Motor Vehicle Coverage and Other Insurance Liability** means any Expenses for services and supplies that are payable under any:

1. automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured
2. or uninsured motorist coverage;
3. homeowner's coverage;
4. commercial premises coverage; or
5. similar policy or insurance.

This applies when the policy or insurance is either issued to, or makes benefits available to a Member, whether or not the Member makes a claim under such coverage. Further, the Member is responsible for any cost-sharing required by the motor vehicle coverage, unless applicable state law requires otherwise. Once benefits under such policy or insurance are exhausted or deemed to no longer be injury-related under the no-fault provisions of the Policy, we will provide benefits according to the Policy.

**Nitrous Oxide**

**Non-Direct Patient Care** and services that are not direct patient care, including:

1. charges for appointments scheduled and not kept ("missed appointments");
2. charges for preparing medical reports, itemized bills or claim forms (even at our request); or
3. visits or consultations that are not in person (including telephone consultations and e-mail exchanges).

**Occlusal Treatment** and supplies provided in connection with dental occlusion, including the following:

1. occlusal analysis and adjustments; and
2. occlusal guards.

**Oral Hygiene Instructions**

**Orthodontic Dental Services** and supplies provided in connection with orthodontics, unless an Orthodontic Benefit Rider is attached to this Policy, including the following:

1. correction of malocclusion;
2. craniomandibular orthopedic treatment;
3. other orthodontic treatment;
4. Class A orthodontic procedures; and
5. procedures for tooth movement, regardless of purpose.

**Personal Comfort Items** primarily used for convenience, contentment, personal hygiene, aesthetics, or other non-therapeutic purposes.

## **Photographic Images**

## **Pin Retention in Addition to Restoration**

## **Precision Attachments**

**Prosthesis Services** and supplies in connection with dental prosthesis, including the following:

1. initial placement of a Prosthetic Device, when the Prosthetic Device is needed to replace one or more natural teeth that were missing prior to when coverage under this Policy became effective for the Member;
2. Surgical placement of a dental implant or an implant supported abutment, repair, maintenance, or removal of a dental implant;
3. maxillofacial prosthetic procedures;
4. modification of removable prosthesis following implant surgery; and
5. replacement services and supplies provided in connection with the replacement of any Prosthetic Device whether lost, stolen, or broken. Replacement of a Prosthetic Device will only be considered a Covered Service if the Prosthetic Device was installed at least 7 years prior to its replacement.

Prosthetic Device includes, but is not limited to, fixed or removable orthodontic appliances, full or partial dentures, fixed or removable bridgework and implants.

## **Provisional Splinting**

## **Riot, Rebellion, War and Illegal Acts**

Services and supplies for treatment of:

1. an illness or injury caused by a Member's unlawful instigation and/or active participation in a riot or war; whether declared or undeclared, armed invasion or aggression, insurrection, or rebellion; or
2. services and supplies for treatment of an illness or injury sustained by a Member while in the act of committing an illegal act.

**Self-Help, Non Dental Self-Care, Training, or Instructional Programs** except for services for training or educating a Member, when provided without separate charge in connection with Covered Services.

## **Separate Charges**

Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including the following:

1. any supplies;
2. local anesthesia; or
3. sterilization.

## **Services and Supplies Provided by a Member of your Immediate Family**

## **Services Performed in a Laboratory**

## **Surgical Procedures**

Services and supplies provided in connection with the following surgical procedures:

1. exfoliative cytology sample collection or brush biopsy;
2. incision and drainage of abscess extraoral soft tissue, complicated or non-complicated;
3. radical resection of maxilla or mandible;
4. removal of nonodontogenic cyst, tumor or lesion;
5. surgical stent; or
6. surgical procedures for isolation of a tooth with rubber dam.

**Temporomandibular Joint (TMJ) Dysfunction Treatment Services** and supplies provided in connection with Temporomandibular joint (TMJ) dysfunction.

**Third Party Liability**

Services and supplies for treatment of Illness or Injury for which a third party is or may be responsible.

**Tooth Transplantation Services** and supplies provided in connection with tooth transplantation, including reimplantation from one site to another and splinting and/or stabilization.

**Travel and Transportation Expenses**

**Treatment, Procedures, Techniques or Therapies Outside Generally Accepted Dental Care Practices.**

**Treatment started prior to the Member's Effective Date under this Policy or completed more than 30 days after coverage under this Policy terminates.**

**Work-Related Conditions** and expenses for services and supplies incurred as a result of any work related Injury or Illness, including any claims that are resolved pursuant to a disputed claim settlement for which a Member has or had a right to compensation.

We may require the Member to file a claim for workers' compensation benefits prior to providing any benefits under the Policy. Services and supplies received for work-related Injuries or Illnesses are not covered even if the service or supply is not a covered workers' compensation benefit. The only exception is if a Member is exempt from state or federal workers' compensation law.

**Disclaimer**

Anything not specifically provided for in the Policy may not be a covered benefit.

## WHEN COVERAGE ENDS

This section describes the situations when coverage will end for you and/or your Enrolled Dependents. If one of your Enrolled Dependents is no longer eligible for this coverage, you must notify us within 30 days.

No person will have a right to receive benefits under this Policy after the date it is terminated. Termination of your or your Enrolled Dependent's coverage under this Policy for any reason will completely end all our obligations to provide you or your Enrolled Dependent benefits for Covered Services received after the date of termination. This applies whether or not you or your Enrolled Dependent is then receiving treatment or is in need of treatment for any Illness or Injury incurred or treated before or while this Policy was in effect.

**Policy Termination or Non Renewal** by the Policyholder or by us means coverage ends for you and your Enrolled Dependents on the date the Policy is terminated or not renewed.

In the event this Policy is terminated and coverage is not replaced by the Policyholder, we will mail to the Policyholder a notice of termination. It is then the duty of the Policyholder to send each Enrolled Employee a notice of the termination, explaining rights to continuation or portability of coverage under federal and/or state law.

**If You Are No Longer Eligible** as explained in the following paragraphs, you and your Enrolled Dependents' coverage ends on the last day of the month in which your eligibility ends. However, it may be possible for you and/or your Enrolled Dependents to continue coverage under the Policy according to the COBRA Continuation of Coverage provisions of this Certificate.

### **Termination of Your Employment or You Are Otherwise No Longer Eligible**

If you are no longer eligible due to termination of employment or you are otherwise no longer eligible according to the terms of the Policy, your coverage will end for you and all Enrolled Dependents on the last day of the month in which eligibility ends.

### **Nonpayment of Premium**

If you fail to make required timely contributions to premium, your coverage will end for you and all Enrolled Dependents on the last day of the period for which you have made any required contribution.

### **Termination by You**

Pre-tax contribution and noncontributory coverage: You have the right to terminate this coverage with respect to yourself and your Enrolled Dependents by giving notice to your Employer during your Annual Enrollment Period or after a Qualifying Life Event. Coverage will end on the last day of the month in which we receive such notice. **Qualifying Life Event** for the purposes of terminating or changing coverage elections includes each of the events described under Section 125 of the Internal Revenue Service code. Please contact your Employer for more information.

Post tax contribution: You have the right to terminate this coverage with respect to yourself and your Enrolled Dependents by giving notice to your Employer. Coverage will end on the last day of the month in which we receive such notice.

As a Retiree, you have the right to terminate this coverage at any time with respect to yourself and your Enrolled Dependents by giving notice to the Policyholder. Coverage will end on the last day of the month in which we receive such notice.

Note: As an active Employee, if you voluntarily terminate your coverage, you will not have the opportunity to re-enroll under the next two annual enrollment periods following your termination date. If you are a Retiree or an Employee under a severance agreement and you voluntarily terminate your coverage you will not have the opportunity to re-enroll at any time.

### **Fraudulent Use of Benefits**

If you or your Enrolled Dependent engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of fact in connection with coverage, coverage under this Policy will terminate for that Member. If this coverage terminates for an Enrolled Employee, it will also terminate for the Employee's Enrolled Dependents.

### **Fraud or Misrepresentation in Application**

We have issued this coverage in reliance upon all information furnished to us by you or on behalf of you and your Enrolled Dependents. In the event of any intentional material misrepresentation of fact or fraud regarding a Member (including, but not limited to a person who is listed as a dependent, but does not meet the eligibility requirements listed in this Certificate), coverage under this Policy will terminate for such Member.

**Family and Medical Leave is applicable** if your Employer grants you a leave of absence under the Family and Medical Leave Act of 1993 (Public Law 103-3, "FMLA").

The Act is generally applicable to private employers of 50 or more employees and public employers of any size. You will be entitled to continued coverage under this provision only to the extent you are eligible for leave under the terms of the FMLA. The following rules apply:

1. you and your Enrolled Dependents will remain eligible to be enrolled under the Policy during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
  - a) in order to care for your newly born child;
  - b) in order to care for your Spouse, child, or parent, if such Spouse, child, or parent has a serious health condition;
  - c) the placement of a child with you for adoption or foster care; or
  - d) you suffer a serious physical or mental health condition.

During the FMLA leave, timely payment of the monthly premium must continue to be made through the Employer. The provisions described here will not be available if this Policy terminates.

If you and/or your Enrolled Dependents elect not to remain enrolled during the FMLA leave, you (and/or your Enrolled Dependents) will be eligible to be reenrolled under the Policy on the date you return from the FMLA leave. In order to reenroll after you return from a FMLA leave, you must sign a new application just as if you were a newly eligible employee. In this situation, if you reenroll within the required time, all of the terms and conditions of the Policy will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or your Enrolled Dependents) will receive credit for any waiting period served prior to the FMLA leave and you will not have to re-serve any probationary period under this Policy, although you and/or your Enrolled Dependents will receive no waiting period credits for the period of non-coverage.

Persons entitled to coverage under this provision will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this provision. Entitlement to FMLA leave does not constitute a qualifying event for the purposes of COBRA continuation. However, a person who does not return to active employment following FMLA leave may be entitled to COBRA continuation coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the FMLA leave.

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern. This leave provision is available only to employers that are required by law to comply. The Employer must keep us advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by FMLA.

**NOTE:** The Family and Medical Leave provision is not available to Retirees or Employees covered under a Severance Agreement.

### **Leave of Absence**

If you are granted a non-FMLA temporary leave of absence by your Employer, you can continue coverage for up to three months. Premiums must be paid through the Employer in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by your Employer at your request during which you are still considered to be employed and are carried on the employment records of the Employer. A leave can be granted for any reason acceptable to the Employer. If you are on leave for an FMLA-qualifying reason, you remain eligible under the Policy only for a period equivalent to FMLA leave and may not also continue coverage under a non-FMLA leave.

**NOTE:** The Leave of Absence provision is not available to Retirees or Employees covered under a Severance Agreement.

### **When your Enrolled Dependents are No Longer Eligible**

If your dependent is no longer eligible as explained in the following paragraphs (unless specified to the contrary below), their coverage will end on the last day of the month in which their eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Policy according to the COBRA Continuation of Coverage provisions of this Certificate.

### **Divorce, Annulment or Termination of Domestic Partnership**

Eligibility ends for your enrolled Spouse and the Spouse's children (unless such children remain eligible by virtue of their continuing relationship to you) on the last day of the month in which a divorce, annulment or termination of domestic partnership is final.

### **If You Die**

If you die, coverage for your Enrolled Dependents ends on the last day of the month in which your death occurs.

### **Loss of Dependent Status**

1. for an enrolled child who is no longer an eligible dependent due to exceeding the dependent age limit, eligibility ends on the last day of the month in which the child exceeds the dependent age limit; or
2. for an enrolled child who marries, eligibility ends on the last day of the month in which the marriage occurs; or
3. for an enrolled child who is no longer eligible due to disruption of placement prior to legal adoption and who is removed from placement, eligibility ends on the date the child is removed from placement; or
4. for an enrolled child who is no longer an eligible dependent for any other cause (not described above), eligibility ends on the last day of the month in which the child is no longer a Dependent.

### **Certificates of Creditable Coverage**

Requests for and inquiries about required certificates relating to period(s) of creditable coverage under the Policy should be directed to the Policyholder, or to us at PO Box 1271, M/S E8L, Portland, OR 97207-1271.

## COBRA CONTINUATION OF COVERAGE

COBRA is a continuation of this coverage for a limited time after certain events cause a loss of eligibility. COBRA continuation does not apply to all groups. Complete details are available from your Employer.

If your Employer is subject to COBRA, COBRA continuation is available to your Enrolled Dependents if they lose eligibility because:

1. your employment is terminated (unless the termination is for gross misconduct); or
2. your hours of work are reduced; or
3. you die; or
4. you and your Spouse divorce, the marriage is annulled; or
5. you and your domestic partner terminate the domestic partnership; or
6. you become entitled to Medicare benefits; or
7. your Enrolled Dependent loses eligibility as a dependent child under this coverage.

COBRA is also available to you if you lose eligibility because your employment terminates (other than for gross misconduct) or your hours of work are reduced. (A special COBRA continuation also applies to you and your Enrolled Dependents under certain conditions if you are retired and your Employer files for bankruptcy. Complete details are available from your Employer.)

There are some circumstances involving disability or the occurrence of a second one of these events that can result in extension of the limited period of continuation following a termination of employment or reduction in working hours. COBRA also can terminate earlier than the maximum periods. See your Employer for details.

### General Rules

Generally, you or your Enrolled Dependents are responsible for payment of the full premium for COBRA continuation, plus an administration fee, even if the Employer contributes toward the premiums of those not on COBRA continuation. The administration fee is 2% or, during any period of extension for disability, 50%.

In order to preserve your and your Enrolled Dependent's rights under COBRA, you or your Enrolled Dependents must inform the Employer in writing within 60 days:

1. of your divorce, annulment, termination of domestic partnership, or loss of dependent child status; or
2. if your initial loss of eligibility was due to your termination of employment or reduction in working hours and you experience another one of the events listed above; or
3. a Social Security disability determination that you or your Enrolled Dependent was disabled for Social Security purposes at the time of a termination of employment or reduction in working hours or within the first 60 days of COBRA continuation following that event. (If a final determination is later made that you or your Enrolled Dependent is no longer disabled for Social Security purposes, you or your Enrolled Dependent must provide the Employer notice of that determination within 30 days of the date it is made.)

The Employer also must meet certain notification, election and payment deadline requirements. It is therefore very important that you keep the Employer informed of the current address of all Members who are or may become qualified beneficiaries.

If you or your Enrolled Dependents do not elect COBRA continuation coverage, coverage under the Policy will end according to the terms of the Policy and we will not pay claims for services provided on and after the date coverage ends. Further, this may jeopardize your or your Enrolled Dependents' future eligibility for an individual plan.

## COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

### Definitions

- A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
1. Plan includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
  2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

- D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
  2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
  3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
  4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
  5. The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
- E. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

### **Order of Benefit Determination Rules**

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
- B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.  
  
(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, 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 so that the Plan covering the person as an employee, member, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
2. **Dependent Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
  - a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
  - b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
    - iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
    - iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The Plan covering the Custodial parent;

The Plan covering the spouse of the Custodial parent; The Plan covering the non-custodial parent; and then

The Plan covering the spouse of the non-custodial parent.
  - c. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

### **Effect On The Benefits Of This Plan**

- A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

### **Right To Receive And Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. LifeMap may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. LifeMap need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give LifeMap any facts it needs to apply those rules and determine benefits payable.

### **Facility Of Payment**

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

### **Right Of Recovery**

If the amount of the payments made by LifeMap is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## CLAIMS PROVISIONS

This section explains a variety of matters related to administering benefits and/or claims, including situations that may arise when your health care expenses are the responsibility of a source other than us.

### Identification Card

When you, the Enrolled Employee, enroll with LifeMap Assurance Company, you will receive an identification card. It will include important information such as your identification number, your Group number, and your name.

It is important to keep your identification card with you at all times. Be sure to present it to your Dentist before receiving care.

If you lose your card, or if it is destroyed, you can obtain a new one by calling our customer service department at (888) 777-9368. If coverage under the Policy terminates, your identification card will no longer be valid.

### Calendar Year and Policy Year

The Calendar Year Deductible and Calendar Year Maximum provisions are generally calculated on a Calendar Year basis. This Policy is renewed, with or without changes, each Policy Year. A Policy Year is the 12-month period following either the Policy's original Effective Date or subsequent renewal date. A Policy Year may or may not be the same as a Calendar Year.

If your Policy is renewed mid-Calendar Year and during that Calendar Year:

1. you paid toward the Calendar Year Deductible, you will get credit for that amount under the renewed Policy for the same Calendar Year; but
2. if the Calendar Year Deductible amount increases mid-Calendar Year, you will need to meet the new Deductible requirement minus any amount you had paid under the previous Benefit Schedule during that same Calendar Year; and
3. if you had an amount accumulated toward the Calendar Year Maximum, this amount will be applied to the Calendar Year Maximum under the renewed Policy during that same Calendar Year.

### When Benefits Are Available

In order for dental expenses to be covered under the Policy, they must be incurred while coverage is in effect. Coverage is in effect when all of the following conditions are met:

1. the person is eligible to be covered according to the eligibility provisions of the Policy;
2. the person has applied for coverage and has been accepted by us; and
3. premium for the person for the current month has been paid by the Policyholder on a timely basis.

The expense of a service is incurred on the day the service is rendered and the expense of a supply is incurred on the day the supply is delivered to you.

### Notice of Claim

Written notice of any loss resulting in a claim being filed under this Policy must be given to us within 20 days after the loss occurs, or as soon as reasonably possible.

### Claim Forms

When notice of claim is received, we will send you the forms for filing proof of loss. If the forms are not received within 15 days, you can send us written proof of loss without waiting for the forms.

### Proof of Loss

Written proof of loss must be received within 90 days after the date of the loss for which a claim is made.

We will not deny or reduce any claim if it was not reasonably possible to furnish us proof in the time required. In any event, proof must be furnished within one year after it is due, unless you are legally incapable of doing so.

## **Dental Claims**

In order for us to pay for Covered Services, you or the Dentist must first send us a claim. Be sure the claim is complete and includes the following information:

1. an itemized description of the services given and the charges for them;
2. the date treatment was given;
3. the diagnosis;
4. the patient's name and the group and identification numbers; and
5. the treating Dentist's name, address, TIN and license number.

## **Participating Dentist Claims**

You must present your identification card when obtaining Covered Services from a Participating Dentist. The Participating Dentist will furnish us with the forms and information we need to process your claim. You are responsible for providing any additional information requested.

## **Participating Dentist Reimbursement**

We will pay a Participating Dentist directly for Covered Services. Participating Dentists have agreed to accept the Allowed Amount as full compensation for Covered Services. Your share of the Allowed Amount is any amount you must pay due to the Calendar Year Deductible and/or Coinsurance. A Participating Dentist may require you to pay your share at the time you receive care or treatment.

## **Nonparticipating Dentist Claims**

In order for us to pay for Covered Services rendered by a Nonparticipating Dentist, you or the Dentist must first send us a claim. Be sure the claim is complete and includes the information listed under Dental Claims.

## **Nonparticipating Dentist Reimbursement**

Nonparticipating Dentists have not agreed to accept the Allowed Amount as full compensation for Covered Services, so you are responsible for paying any difference between the amount billed by the Nonparticipating Dentist and the Allowed Amount, in addition to any amount you must pay due to the Calendar Year Deductible and/or Coinsurance.

**Freedom of Choice of Dentist** means that nothing contained in the Policy is designed to restrict you in selecting the Dentist of your choice for dental care or treatment. You may choose to see any Dentist at the time of treatment, however as stated above, you are responsible for paying any difference between the amount billed by the Nonparticipating Dentist and the Allowed Amount, in addition to any amount you must pay due to the Calendar Year Deductible and/or Coinsurance.

## **Time Payment of Claim**

Losses covered by this Policy will be paid by us as soon as we receive:

1. the bills which substantiate proof of loss; and
2. any medical/dental information we request.

## **Payment of Claim**

1. We have the sole right to decide whether to pay you, the provider, or you and the provider jointly.
2. We may make benefit payments for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child.
3. If a person entitled to receive payment under the Policy has died, is a minor, or is incompetent, we may pay the benefits (up to \$1,000) to a relative by blood or marriage of that person who we believe is equitably entitled to the payment.
4. A payment made in good faith under this provision will fully discharge us to the extent of the payment.

## **Claims Determinations**

Within 30 days of our receipt of a claim, we will notify you of the action we have taken on it, adverse or not. However, this 30-day period may be extended by an additional 15 days in the following situations:

1. when we cannot take action on the claim due to circumstances beyond our control, we will notify you within the initial 30-day period that an extension is necessary. This notification includes an explanation of why the extension is necessary and when we expect to act on the claim; or
2. when we cannot take action on the claim due to lack of information, we will notify you within the initial 30-day period that the extension is necessary. This notification includes a specific description of the additional information needed and an explanation of why it is needed.

We must allow you at least 45 days to provide us with the additional information if we are seeking it from you. If we do not receive the requested information to process the claim within the time we have allowed, we will deny the claim.

If we receive an inquiry regarding a properly submitted claim and we believe that you expect a response to that inquiry, we will respond to the inquiry within 30 days of the date we first received it.

## **Explanation of Benefits**

We will report to you actions taken on a claim. We use a form called an explanation of benefits. We may pay claims or deny them. If we deny all or part of a claim, the reason for our action will be stated on the explanation of benefits. The explanation of benefits will also include instructions for filing an Appeal or Grievance if you disagree with the action.

## **Assignment**

No assignment by any Member of any coverage under the Policy shall be valid, except that this provision will not prohibit payment of benefits to providers of services and supplies for expenses covered by provisions of the Policy.

## **Claims Recovery**

If we pay a benefit to which you or your Enrolled Dependent was not entitled, or if we pay a person who is not eligible for benefits at all, we have the right to recover the payment from the person we paid or anyone else who benefited from it, including a provider of services. Our right to recovery includes the right to deduct the mistakenly paid amount from future benefits we would provide the Enrolled Employee or any of their Enrolled Dependents, even if the mistaken payment was not made on that person's behalf.

This claims recovery provision in no way reduces our right to reimbursement or subrogation.

### **Right to Receive and Release Necessary Information and Dental Records**

It is important to understand that your health information may be requested or disclosed by us. This information will be used for the purpose of facilitating health care treatment, payment of claims, or business operations necessary to administer health care benefits; or as required by law.

The information requested or disclosed may be related to treatment or services received from:

1. an insurance carrier or group health plan;
2. any other institution providing care, treatment, consultation, pharmaceuticals or supplies;
3. a clinic, hospital, long-term care or other medical facility; or
4. a physician, Dentist, pharmacist or other physical health care practitioner.

Health information requested or disclosed by us may include, but is not limited to:

1. billing statements;
2. claim records;
3. correspondence;
4. dental records;
5. diagnostic imaging reports;
6. hospital records (including nursing records and progress notes);
7. laboratory reports; or
8. medical records.

Note: This provision does not apply to information regarding HIV/AIDS, psychotherapy notes, alcohol/drug services, and genetic testing.

# GENERAL PROVISIONS

## **Entire Contract-Policy Changes**

This Certificate is furnished in accordance with and subject to the terms of the Policy. The entire contract consists of the Policy, which includes the Application, and any attached papers; this Certificate; and any riders or endorsements. No change in the Policy will be effective until approved by one of our officers. This approval can only be made in writing and must be noted on or attached to the Policy. No agent has authority to change the Policy or Certificate or to waive any of their provisions.

## **Certificates**

The Employer is responsible for giving to the Enrolled Employee a complete copy of the Certificate for the Employee's applicable class within 31 days after receipt of the Certificates from us.

## **Agency**

For all purposes under this Policy the Policyholder acts on its own behalf or as agent of the Enrolled Employee. Under no circumstances will the Policyholder be deemed our agent without a written authorization.

## **Bankruptcy**

If bankruptcy, receivership, or liquidation proceedings are commenced with respect to the Policyholder, and if this Policy has not otherwise been terminated, then LifeMap may suspend all further performance of this Policy pursuant to Section 365 of the Bankruptcy Code or any similar or successor provision of Federal or State law. Any such suspension of further performance by LifeMap pending the Policyholder's assumption or rejection of this Policy will not be a breach of this Policy and will not affect LifeMap's right to pursue or enforce any of its rights under this Policy or otherwise.

## **Incontestability**

In the absence of fraud, all statements you make in an application will be deemed representations and not warranties. No statement made for the purpose of obtaining coverage will void such coverage or reduce benefits unless contained in a written document signed by you, a copy of which is furnished to you.

## **No Waiver**

The failure or refusal of either party to demand strict performance of this Policy or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of the Policy will be deemed waived by us unless such waiver is reduced to writing and signed by one of our authorized officers.

## **Legal Action**

No legal action may be brought to recover on this Policy until 60 days after proof of loss has been furnished. No action may be brought after 3 years from the time written proof of loss is required to be furnished.

## **Limitations on Liability**

In all cases, you have the exclusive right to choose a dental care provider. We are not responsible for the quality of dental care you receive. Since we do not provide any dental care services, we cannot be held liable for any claim or damages connected with injuries you suffer while receiving dental services or supplies provided by professionals who are neither our employees nor agents.

In addition, we will not be liable to any person or entity for the inability or failure to procure or provide the benefits of this Policy by reason of epidemic, disaster, or other cause or condition beyond our control.

## **Worker's Compensation**

This insurance is not in lieu of Workers' Compensation; it does not affect any requirement for Workers' Compensation coverage.

**Notices** to Members or to the Employer required in the Policy will be deemed to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Enrolled Employee or to the Employer will be addressed to the Enrolled Employee or to the Employer at the last known address appearing in our records. If we receive a United States Postal Service change of address form (COA) for an Enrolled Employee, we will update our records accordingly. Additionally, we may forward notice for an Enrolled Employee to the plan administrator if we become aware that we don't have a valid mailing address for the Enrolled Employee.

Any notice to us required in the Policy may be given by mail addressed to: LifeMap Assurance Company, PO Box 1271, M/S E8L, Portland, OR 97207-1271; provided, however that any notice to us will not be deemed to have been given to and received by us until physically received by us.

## **RESOLVING YOUR CONCERNS**

If you believe a policy, action, or decision of ours is incorrect, please contact our customer service department. If we cannot resolve your concern to your satisfaction, you or your Representative (any Representative authorized by you) may pursue the Appeal Process.

If you have concerns regarding a decision, action, or statement by your provider, we encourage you to discuss these concerns with the provider. If you remain dissatisfied after discussing your concern with your provider, you may file a Grievance with our customer service department. However, if you would prefer to discuss your concern with us rather than your provider, please contact our customer service department.

## **APPEALS**

### **Claims Appeal Procedure**

You will be given notice if a claim or request for services or supplies is denied in whole or in part. If you or your Enrolled Dependent are not satisfied with the decision, the claim or request may be resubmitted (along with any additional information which would affect the decision) to us for reconsideration. This must be done within 180 days after the denial is received.

We will review the appeal and any additional information submitted. You will be given written notice of our decision within 30 days after the appeal for review was received by us. If more extensive review is needed, the written notice of our decision will be given within 120 days after the appeal was received. If the additional time for review is needed, we will notify you within 30 days.

All written appeals should be sent to the address below.

LifeMap Assurance Company  
P.O. Box 1334  
Milwaukee, WI 53201

Additional Information about the Claims Appeal Procedure can be obtained by contacting our customer service department at (800) 756-4105, or you can write to our customer service department at the following address: LifeMap Assurance Company, Attention: Dental Customer Service, PO Box 1334, Milwaukee, WI 53201.



LifeMap Assurance Company®  
200 SW Market Street  
P.O. Box 1271, M/S E8L  
Portland, OR 97207-1271  
(503) 721-7161 • (800) 794-5390

## ORTHODONTIC BENEFITS RIDER 14

**Orthodontic Benefits Rider Effective Date:** April 1, 2016

It is agreed that the Group Dental Policy to which this Rider is attached is amended on the date shown above to include the following orthodontic benefits.

**Covered Members Include:** All Enrolled Members

**Calendar Year Deductible:** The Calendar Year Deductible, as shown under the Benefits Schedule of the Policy to which this Rider is attached, does not apply to this Orthodontic Benefits Rider.

**Benefit Waiting Period:** None

**Coinsurance:** 50% of Covered Orthodontic Services

**Orthodontia Lifetime Maximum:** \$1,500

Orthodontia Lifetime Maximum means the total amount of orthodontia benefits paid throughout a Member's lifetime while covered under any dental policy.

For the purposes of this Rider Covered Orthodontic Services include:

- Initial orthodontic exam, study models and x-rays that may be needed to complete a treatment plan.
- The initial and subsequent installations of orthodontic appliances and all non-surgical orthodontic treatments concerned with the reduction or elimination of an existing malocclusion, subject to the approval of a treatment plan (submitted by the Dentist or Licensed Orthodontist). The treatment plan should include all of the following information:
  - a diagnosis indicating an abnormal occlusion that can be corrected by orthodontic treatment;
  - the estimated length of required treatment;
  - the initial banding fee; and
  - the total orthodontic treatment charge.

- If treatment stops before the end of the prescribed treatment period, benefits will end on the last day of the month during which the treatment was discontinued.
- We will credit newly eligible Employees if they had orthodontia coverage immediately before coverage begins under this Policy, with time served toward the Benefit Waiting Period shown above.

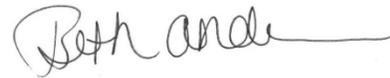
**ALL OTHER TERMS AND CONDITIONS OF THIS POLICY REMAIN UNCHANGED.**

**LIFEMAP ASSURANCE COMPANY**

Chairman, Dudley Slater



President, Beth Andersen



## ERISA INFORMATION

The following information is provided in accordance with the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). This Willamette University document, together with the Certificate of Coverage issued by LifeMap Assurance Company, is the Summary Plan Description (SPD) required by the Employee Retirement Income Security Act of 1974 ("ERISA"). This Willamette University document is not intended to give you any substantive rights to benefits that are not already provided by the attached Certificate of Coverage. The following information is furnished by the Plan Administrator and is not a part of the Group Policy or this Certificate of Coverage. LifeMap Assurance Company assumes no responsibility for the accuracy or sufficiency of the information in this section. For complete information required by ERISA, contact the Plan Administrator.

**Plan Name:**

Willamette University Group Dental Insurance Policy

**Plan Sponsor:**

Willamette University  
900 State Street  
Salem Oregon 97301  
Phone: (503) 375-5443

**Plan Numbers:**

The Plan is identified by the following numbers under the Internal Revenue Service rules:  
Employer Identification Number (EIN): 93-0386972

Plan Number (PN): 512

**Type of Welfare Plan:**

This is a Group Dental Insurance Benefit Plan

**Plan Year:**

The Plan year begins January 1 and ends December 31.

**Type of Plan Administration:**

The Plan is fully insured. Benefits are provided under a group insurance contract entered into between Willamette University and LifeMap Assurance Company. Claims for benefits are sent to the Insurance Company. The Insurance Company is responsible for determining eligibility for and the amount of any benefits payable under the Plan and for providing the claims procedures to be followed and the claims forms to be used by employees pursuant to the Plan. The Insurance Company also has the authority to require employees to furnish it with such information as it determines is necessary for the proper administration of the Plan.

**Plan Administrator and Named Fiduciary:**

Willamette University  
Attn: Human Resources  
900 State Street  
Salem Oregon 97301  
Phone: (503) 375-5443

**Agent For Service of Legal Process:**

Willamette University  
900 State Street  
Salem Oregon 97301  
Phone: (503) 375-5443  
Service of legal process may also be made on the Plan Administrator.

**Insurance Company**

LifeMap Assurance Company  
P.O. Box 1271 M/S E8L  
Portland, Oregon 97207-1271  
Tel: (503) 412-7965  
Toll-free: (800) 286-1129

**Sources and Methods of Contributions to the Plan:**

Insurance premiums for employees and their covered dependents may be paid in part by the Plan Sponsor out of its general assets, and in part by employee payroll deductions.

Contact the Plan Sponsor for a schedule of the applicable premiums.

Any employee payroll deductions shall be used in their entirety prior to using Plan Sponsor contributions to pay for premiums under this plan. Any refund, rebate, dividend, experience adjustment, or other similar payment under the group insurance contracts entered into between Willamette University and the Insurance Company shall be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse Willamette University for premiums that it has paid.

**Plan Amendment or Termination Provisions:**

The Plan Sponsor has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument signed by the Plan Sponsor President or Human Resources Manager, both of whom are authorized to amend or terminate the Plan and to sign insurance contracts with the Insurance Company or other carriers, including amendments to those contracts. In addition, termination of the group insurance contract entered into between the Plan Sponsor and Insurance Company will constitute termination of the Plan, unless the Plan Sponsor exercises its sole discretion to obtain a substitute contract of insurance.

If the Plan is terminated, Members will not have any further rights, other than the payment of benefits for covered expenses incurred before the Plan was terminated. The amount and form of any final benefit will depend on any provisions affecting the Plan, and the Plan Sponsor's decisions.

**Important Disclaimer:**

Benefits hereunder are provided solely pursuant to an insurance contract between the Plan Sponsor and the Insurance Company. If the terms of this summary document conflict with the terms of the insurance contract, the terms of the insurance contract will control, unless superseded by applicable law.

## STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 as amended ("ERISA"). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's principal office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

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

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

## **CLAIM REVIEW PROCEDURES**

The Insurance Company is responsible for evaluating all benefit claims under the Plan. The Insurance Company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA.

See the attached Certificate of Coverage issued by LifeMap Assurance Company for information about how to file a claim and for details regarding the Insurance Company's claims procedures.

The Plan will make every effort to make a determination on dental claims within 30 days of receipt of the claim.

If the Plan is not able to make a decision on the claim within 30 days of receipt of the claim for reasons beyond the control of the Plan, the decision may be extended for as many as 15 additional days. If this is the case, written notice will be provided to the claimant prior to the end of the first 30 days that details the specific reason(s) for the delay. The notice will identify the additional information or documents needed to resolve the claim.

The maximum time the Plan will take to make a decision on the claim will be 90 days.

## **CLAIM APPEAL PROCEDURES**

If a dental claim or request for services or supplies is denied in whole or in part, the Plan will provide the claimant with a letter stating the specific reason(s) for the adverse determination. The claimant will also be provided with a description of any additional information or material necessary to perfect the claim and an explanation as to why such material is necessary.

The claimant will have 180 days following receipt of an adverse benefit determination to file an appeal. Another person may be authorized to act for the claimant under this appeal procedure.

The appeal will be decided within 30 days after receipt of the appeal. The 30 day time period will start when the appeal is filed without regard to whether all of the information necessary to decide the appeal accompanies the filing.

If, for reasons beyond the control of the Plan, the appeal cannot be decided within 30 days, the appeal decision may be extended for as many as 90 additional days. The maximum time to decide the appeal will be 120 days.