

PLAN DOCUMENT

DENTAL BENEFIT PLAN

FOR THE EMPLOYEES OF:

**RANDALL COUNTY**

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**PART I**  
**GENERAL INFORMATION**

## INTRODUCTION

Whereas, Randall County, hereinafter referred to as the "Company", hereby establishes the benefits, rights and privileges which shall pertain to Participating Employees, hereinafter referred to as "Participants", and the Eligible Dependents of such Participants, as herein defined, and which benefits are provided through a group dental plan established by the Company which is hereinafter referred to as the "Plan".

**PURPOSE** - The purpose of the Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of "Eligible Dental Expenses", as herein defined.

**EFFECTIVE DATE** - The effective date of the Plan is October 1, 2009.

**PLAN SUPERVISOR** - The supervisor of the Plan is:

Insurance Management Services  
P. O. Box 15688  
Amarillo, Texas 79105

(806) 373-5944.

[www.imstpa.com](http://www.imstpa.com)

**PLAN NUMBER** - The plan number is 502.

**NAMED FIDUCIARY AND PLAN ADMINISTRATOR** - The Named Fiduciary and Plan Administrator is

Randall County  
400 16<sup>th</sup> Street, Suite B100  
Canyon, Texas 79105

806-477-1701

The Named Fiduciary and Plan Administrator shall have the authority to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Company shall have the authority to amend the Plan, to determine its policies, to appoint and remove supervisors and agents, fix their compensation (if any), and exercise general administrative authority over them. The Administrator has the sole and discretionary authority to determine eligibility for benefits, to review and make final decisions on all claims for benefits including, without limitation, factual determinations; and to construe the terms of the Plan including without limitation, correcting any defect, supplying any omission and reconciling any inconsistency.

**EMPLOYER IDENTIFICATION NUMBER** - The Employer Identification Number is 75-6001120.

**CONTRIBUTIONS TO THE PLAN** - The amount of contributions to the Plan are to be made on the following basis:

The Company shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Company and the amount to be contributed (if any) by each Participant.

Notwithstanding any other provision of the Plan, the Company's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Company's obligation with respect to such payments.

In the event that the Company terminates the Plan, then as of the effective date of termination, the Company and Covered Participants shall have no further obligation to make additional contributions to the Plan.



## DEFINITIONS

Certain words and phrases used in this Plan Document are listed below, along with the definition or explanation of the manner in which the term is used for the purposes of this Plan.

Masculine pronouns used in this Plan Document shall include masculine or feminine gender unless the context indicates otherwise.

Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

**ADVERSE BENEFIT DETERMINATION** – The term “Adverse Benefit Determination” means a denial, reduction or termination of, or a failure to provide or make payment (in whole or part), for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Participant’s or beneficiary’s eligibility to participate in a Plan.

**ALTERNATE RECIPIENT** - The term “Alternate Recipient” shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant’s Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent.

**AMENDMENT** – The term “Amendment” means a formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Administrator.

**APPROPRIATE HEALTH CARE PROFESSIONAL** – The term “Appropriate Health Care Professional” means a person who meets all of the following requirements:

1. Must be a Physician or other health care professional who is licensed, accredited or certified to perform specified health services under state law;
2. Must have appropriate training and experience in the field of medicine involved in the decision; and
3. Was not consulted in connection with the benefit determination that is the subject of the appeal, nor is a subordinate of the person who was consulted.

**AUTHORIZED REPRESENTATIVE** – The term “Authorized Representative” means the person who the Claimant appoints to act on his behalf with respect to a benefit claim or appeal of a denial.

**BENEFIT PERCENTAGE** - The term "Benefit Percentage" means that portion of Eligible Dental Expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any out-of-pocket expenses in excess of the annual deductible that are to be paid by the Participant.

**CHIP** - The term "CHIP" refers to the Children’s Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

**CHIPRA** - The term "CHIPRA" refers to the Children’s Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

**CLAIMANT** - See Covered Person

## DEFINITIONS (Cont'd)

**CLOSE RELATIVE** - The term "Close Relative" means the spouse, parent, brother, sister, child or spouse's parent of the Covered Person.

**COBRA** - The term "COBRA" refers to the Consolidated Omnibus Budget Reconciliation Act of 1985 or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

**COBRA CONTINUEE** - The term "COBRA Continuee" means a person who is receiving continuation coverage under a group dental care plan maintained by the Company. A person shall cease to be a COBRA Continuee on the date that the "maximum required period" ends for the "qualifying event" giving rise to his continuation coverage or if earlier, when COBRA coverage terminates hereunder.

**COLLEGE** - See definition of University.

**COMPANY** - The term "Company" means Randall County, and any other affiliates that adopt the Plan.

**COSMETIC PROCEDURE** - The term "Cosmetic Procedure" means a procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily function.

**COVERED EXPENSE** - The term "Covered Expense" means any necessary dental treatments, services or supplies that are not specifically excluded from coverage elsewhere in this Plan.

**COVERED PERSON** - The term "Covered Person" means any Participant or Dependent of a Participant meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

**DEDUCTIBLE** - The term "Deductible" means a specified dollar amount of Covered Expenses that must be incurred during a Benefit Period before any other Covered Expenses can be considered for payment according to the applicable Benefit Percentage.

**DENTIST** - The term "Dentist" means a person licensed to practice dentistry by the state in which he or she practices and is acting within the scope of his or her license. A Dentist shall not include the Covered Person or any Close Relative of the Covered Person.

**DENTAL HYGIENIST** - The term "Dental Hygienist" means a person licensed to practice dental hygiene by the state in which he or she practices and is acting under the supervision and direction of a Dentist.

**DENTAL TREATMENT PLAN** - The term "Dental Treatment Plan" is a Dentist's report recommended treatment on a form satisfactory to the Plan Supervisor, which itemizes the dental procedures and charges required for the necessary care of the mouth and are accompanied by supporting x-rays and any other appropriate diagnostic materials as required.

**DEPENDENT** - The term "Dependent" means:

1. The Participant's legal spouse who is a resident of the same country in which the Participant resides. Such spouse must have met all requirements of a valid marriage contract in the State of marriage of such parties. A marriage license or common law certificate may be required. If the marriage is a Domestic Partnership, an Affidavit of Same Sex Marriage will be required.
2. The Participant's child who meets all of the following conditions:
  - a. Is a resident of the same country in which the Participant resides;
  - b. Is unmarried;

## DEFINITIONS (Cont'd)

### **DEPENDENT** (Cont'd)

- c. Is a Natural Child, stepchild, legally adopted child, child for whom legal adoption proceedings have been initiated if such child has been placed in your home or a child who has been placed under the legal guardianship of the Participant. A Natural Child qualifies as a Dependent at the time of birth. A Natural Child means a child that is related by birth and is not an adopted child, a stepchild, a foster child, niece, nephew, or grandchild.
  - d. A Domestic Partner's Natural Child who resides with the Participant and who is chiefly dependent on the Participant for financial support. This child must also meet all other eligibility requirements of a Dependent child.
  - e. Is less than twenty-five (25) years of age. The age requirement is waived for any mentally retarded or physically handicapped child, provided that the child is incapable of self-sustaining employment and is chiefly dependent upon the Participant for support and maintenance. Proof of incapacity must be furnished to the Company, and additional proof may be requested from time to time.
3. As required by the Federal Omnibus Budget Reconciliation Act of 1993, any child of a Plan Participant who is an Alternate Recipient under a Qualified Medical Child Support Order (QMCSO) and has a right to enroll in the Plan as a Dependent of a Participant.

Those situations specifically excluded from the definition of a Dependent are:

1. A spouse who is legally separated or divorced from the Participant. Such spouse must have met all requirements of a valid separation or divorce contract in the state granting such separation or divorce;
2. Any person on active military duty;
3. Any person eligible for coverage under this Plan as an individual Participant;
4. Any person who is covered as a Dependent by more than one Participant of the same Company.

**DEPENDENT COVERAGE** - The term "Dependent Coverage" means eligibility under the terms of the Plan for benefits payable as a consequence of Eligible Medical Expenses incurred for an Illness or Injury of a Dependent.

**ELIGIBLE DENTAL EXPENSES** - See Covered Expenses.

**EMPLOYEE** - The term "Employee" means an individual:

1. Whose relationship to an Employer is within the meaning of "employee" for Federal tax withholding purposes; and
2. Who is not a Leased Employee, treated as an independent contractor by an Employer or any employee of such person, even if such person is later reclassified as an Employee on the payroll records of an Employer, or is otherwise compensated by an Employer outside of its normal payroll. A former Employee may be treated as an Employee hereunder during the time that such individual is receiving COBRA continuation coverage under this Plan.

**ENROLLMENT DATE** - The "Enrollment Date" means the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

## DEFINITIONS (Cont'd)

**FAMILY** - The term "Family" means a Covered Person and his eligible dependents.

**FMLA** – The term "FMLA" refers to the Family Medical and Leave Act of 1993, or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

**FULL-TIME EMPLOYEE** - The term "Full-time Employee" means a basis whereby a Participant is employed, and is compensated for services, by the Company for at least the number of hours per week stated in the eligibility requirements. The work may occur either at the usual place of business of the Company or at a location to which the business of the Company requires the participant to travel.

**FUNCTIONING NATURAL TOOTH** – The term "Functioning Natural Tooth" means that part of tooth that is formed by the human body that maintains arch length space, is utilized in the masticatory function; and is adequately supported by the surrounding structures.

**INCURRED EXPENSES** - The term "Incurred Expenses" means those services and supplies rendered to a Covered Person. Such expenses shall be considered to have occurred at the time or date the service or supply is actually provided.

**INJURY** - The term "Injury" means a condition caused by accidental means that result in damage to the Covered Person's body from an external force.

**LATE ENROLLEE** - The term "Late Enrollee" means a Participant or eligible Dependent who enrolls under the plan other than during the first period in which the individual is eligible to enroll under the plan.

**LEASED EMPLOYEE** - The term "Leased Employee" means an individual who is not paid through an Employer's payroll and who is typically compensated by a company (e.g., an employee leasing company or temporary agency) other than an Employer.

**MEDICAL CHILD SUPPORT ORDER** - The term "Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

**NAMED FIDUCIARY** - The term "Named Fiduciary" means Randall County, which has the authority to control and manage the operation and administration of the Plan.

**NATIONAL MEDICAL SUPPORT NOTICE**- The term "National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

## DEFINITIONS (Cont'd)

**NATURAL CHILD** – The term “Natural Child” means a child that is related by birth and is not an adopted child, a stepchild, a foster child, niece, nephew or grandchild.

**OPEN ENROLLMENT DATE** - The initial Open Enrollment Date established by the Plan will be October 1, 2009. Thereafter the Open Enrollment Date will be October 1 of each year.

**OPEN ENROLLMENT PERIOD** - The term “Open Enrollment Period” means the period of time established by the Plan Administrator during which eligible Late Enrollees who have not previously enrolled in the Health Plan may do so. The Open Enrollment Period is the month of August immediately preceding the Open Enrollment Date established by the Plan.

**ORTHODONTIC TREATMENT** – The term “Orthodontic Treatment” means the corrective movement of teeth through bone by means of an active appliance to correct a malocclusion.

**ORTHOTIC APPLIANCE** - The term "Orthotic Appliance" means a casted external device intended to correct any defect in form or function of the human body.

**PARTICIPANT** - The term “Participant” means an Employee who meets the eligibility requirements and who is properly enrolled in the Plan.

**PARTICIPANT COVERAGE** - The term "Participant Coverage" means coverage hereunder providing benefits payable as a consequence of an injury or illness of a Participant.

**PLACEMENT FOR ADOPTION** – The term “Placement for Adoption” means that a child has been placed in the home and is living with the Participant after the formal legal adoption proceedings have been initiated.

**PLAN** - The term "Plan" means without qualification, this Plan Document.

**PLAN ADMINISTRATOR** - The term "Plan Administrator" means the Company, which is responsible for the day-to-day functions and management of the Plan. The Plan Administrator, in its sole discretion, may employ persons or firms to process claims and perform other Plan connected services.

**PLAN SPONSOR** – The term “Plan Sponsor” means KEYBOARD.

**PLAN SUPERVISOR** - The term “Plan Supervisor” means a person or firm hired by the Plan Administrator to perform claims processing and other specified administrative services in relation to the Plan. The Plan Supervisor is not an insurer of Dental benefits under this plan or a fiduciary of the plan and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Plan Supervisor is not responsible for the Plan financing and does not guarantee the availability of benefits under the Plan.

**PLAN YEAR**- The term "Plan Year" means a period of time commencing on October 1 and ending on September 30.

**POST-SERVICE CLAIM** – The term “Post-Service Claim” is any claim with respect to which plan approval is not a prerequisite to obtaining dental services and payment is being requested for dental care already rendered to the Claimant.

## DEFINITIONS (Cont'd)

**QUALIFIED MEDICAL CHILD SUPPORT ORDER**- The term "Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth in the definition of "National Medical Support Notice";
2. Identifies either the specific type of coverage or all available group health coverage. If the Company receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Company and the Plan Administrator will assume that all are designated; or
3. Informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and
4. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated Dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Beneficiaries without regard to this provision, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

**RELEVANT INFORMATION** – The term "Relevant Information" includes documents, records and information if:

1. It was relied upon in making the benefit determination;
2. It was submitted, considered or generated in the course of the benefit determination, whether or not it was relied upon;
3. It demonstrates compliance with the requirements of the new regulations that claim determinations are made in accordance with plan documents and that, where appropriate, the plan provisions have been applied consistently with similarly situated Claimants; or
4. It constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for the Claimant's diagnosis, whether or not it was relied upon.

**UNIVERSITY** - The term "University" means an institution accredited as a college or university by the state in which the institution is located.

## DEFINITIONS (Cont'd)

**USERRA LEAVE** – The term "USERRA Leave" refers to a leave of absence taken by an Employee Participant for a call to military duty that is protected by the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

**USUAL AND CUSTOMARY** - The term "Usual and Customary" refers to the designation of a charge as being the usual charge made by a Physician or other provider of services, supplies, medications, or equipment that does not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same area. The term "area" in this definition means county or such other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill or expertise.

**WAITING PERIOD** - The term "Waiting Period" means the time that must pass before an Employee or Dependent is eligible to enroll in the Plan. Notwithstanding the foregoing, the time between the dates a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage shall not be treated as a Waiting Period.

## **ELIGIBILITY FOR COVERAGE**

Coverage provided under this Plan for Participants and their Dependents shall be in accordance with the Eligibility for Coverage, Effective Date of Coverage, Termination of Coverage and Continuation of Coverage under the COBRA provisions as stated in this Plan Document.

Any change in the amount of coverage available to a Covered Person occasioned by a change in the Participant's classification shall become effective automatically on the classification change date.

**PARTICIPANT ELIGIBILITY** - A Participant eligible for Participant Coverage under this Plan shall include only Full-time Employees who meet all of the following conditions:

1. Is employed by the Company on a permanent Full-time basis for at least forty (40) regularly scheduled hours per week; and
2. Has been continuously employed for a period of forty-two (42) days, which is the Waiting Period.

For purposes of the above requirements only, an Employee shall be deemed continuously employed if the Employee is absent from work due to a health factor. It is important to note that, as set forth in the section entitled "Participant Effective Date," the Employee must actually report for and begin work in order for his coverage to become effective.

Independent contractors, Leased Employees and temporary Employees shall not be deemed to meet the definition of "Employee" or "Full-Time Employee."

A Participant eligible for Dependent Coverage shall be any Participant whose Dependents meet the definition of a Dependent as stated earlier in the Plan. Each Participant will become eligible for Dependent Coverage on the latest of the following:

1. The date he becomes eligible for Participant Coverage; or
2. The date on which he first acquires a Dependent; or

If both the husband and wife are employed by the Company, and both have Dependent children eligible for Dependent Coverage, either the husband or wife but not both, may elect Dependent Coverage for their eligible Dependent children.

**DEPENDENT ELIGIBILITY** - A Dependent will be considered eligible for coverage on the date the Participant becomes eligible for Dependent Coverage, subject to all limitations and requirements of this Plan, and in accordance with the following:

1. Newborn or newly adopted children will be eligible from the moment of birth or placement for adoption, provided the child is properly enrolled as a Dependent of the Participant within thirty (30) days of the child's date of birth or placement for adoption.
2. A spouse will be considered an eligible Dependent from the date of marriage, provided the spouse is properly enrolled as a Dependent of the Participant within thirty (30) days of the date of marriage.
3. If a Dependent is acquired, other than at the time of his birth, due to a court order decree, marriage or adoption or placement for adoption that Dependent will be eligible from the date of such court order decree, marriage or adoption or placement for adoption provided that this new Dependent is properly enrolled as a Dependent of the Participant within thirty (30) days of the court order decree, marriage or adoption or placement of adoption.

## **ELIGIBILITY FOR COVERAGE (Cont'd)**

### **DEPENDENT ELIGIBILITY (Cont'd)**

4. A child may become eligible for Dependent Coverage as set forth in a qualified medical child support order (QMCSO). The Plan Administrator shall have sole discretion to determine whether a medical child support order is qualified and for administering the provision of benefits under the Plan pursuant to a qualified medical child support order. The Plan Administrator may seek clarification and modification of the order, up to and including the right to seek a hearing before the court or agency that issued the order.

No Dependent shall be denied enrollment in the Plan due to his confinement in a hospital or other health care institution or inability to engage in normal life activities.

### **RETIREE ELIGIBILITY**

A Retired Employee is a former active employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

A Retired Employee and eligible dependents of Retired Employees will be considered eligible for coverage, subject to all limitations and requirements of this Plan, if they meet all of the following conditions:

The Retired Employee and dependents were covered by the Plan on the day immediately preceding the date of retirement.

## **EFFECTIVE DATE OF COVERAGE**

**PARTICIPANT EFFECTIVE DATE** Participant Coverage under the Plan shall become effective on the first day of the month coinciding with or next following the date the Participant becomes eligible provided written application for such coverage is made on or before such date. If application is made after the initial date of eligibility (other than during a special enrollment period available to Special Enrollees), the Participant shall be a late Enrollee and coverage for the eligible Employee shall not become effective until the end of the next Enrollment Period.

In order for an Employee's coverage to become effective, an employee must actually report for and begin work. If the Employee is unable to report for and begin work as scheduled (even if such inability is due to a health factor), then his coverage will become effective on such later date when the Employee reports for and begins work.

**DEPENDENT EFFECTIVE DATE** - A Dependent of a Participant who makes written request for Dependent Coverage hereunder, on a form approved by the Plan Administrator, shall be subject to the provisions of this article, becomes covered as follows:

1. If the Participant makes such written request on or before the date he becomes eligible for Dependent Coverage he shall become covered, with respect to those persons who are then his Dependents, on the date he becomes eligible for Participant Coverage.
2. Except as otherwise provided under "Dependent Eligibility" (i.e., for Newborn, adopted, and newly acquired Dependents). If the Participant makes such written request after the date on which he is eligible for Dependent Coverage, those persons who are then his Dependents shall be Late Enrollees, and coverage for the eligible Dependent shall not become effective until the end of the next Open Enrollment Period.

**SPECIAL ENROLLMENT EFFECTIVE DATE** - Eligible Employees and Dependents are permitted to enroll in this Plan upon loss of other group health coverage if enrollment is requested by the Employees within thirty (30) days of loss of coverage. The Special Enrollee must meet the following conditions:

1. The Employee or Dependent had other Creditable Coverage or was under a COBRA continuation provision at the time coverage was offered by this Plan and the Employee stated in writing that coverage under another plan was the reason for declining enrollment; and
2. The Employee or Dependent lost such coverage due to divorce, legal separation, death, termination of employment, reduction of hours, termination of employer contribution, or established COBRA coverage exhausted. Loss of coverage because of non-payment of premium is not a condition to qualify for Special Enrollment.
3. The effective date for the above Special Enrollee shall be the day following the loss of other group health coverage provided proper enrollment is completed within thirty (30) days of loss of coverage.

An Employee who is already enrolled in a benefit option may enroll in another benefit option under the Plan if a Dependent of that Employee has a special enrollment right in the Plan because the Dependent lost eligibility for other coverage. The Employee must make written application for special enrollment in the new benefit option within 30 days of the date the other health coverage was lost.

## EFFECTIVE DATE OF COVERAGE (Cont'd)

**CHIPRA SPECIAL ENROLLMENT EFFECTIVE DATE** - This Plan will permit Employees and Dependents who are eligible, but not enrolled for coverage, to enroll in two additional circumstances:

1. The employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the employee requests coverage under the Plan within sixty (60) days after the termination or,
2. The employee or Dependent become eligible for a premium assistance<sup>3</sup> subsidy under Medicaid or CHIP, and the employee requests coverage under the Plan within sixty (60) days after eligibility is determined.

The Employee must make written application for CHIPRA Special Enrollment within sixty (60) days of the date that Medicaid or CHIP coverage was lost, or within sixty (60) days of the determination that the employee or Dependent is eligible for a premium assistance subsidy. The effective date for the CHIPRA Special Enrollee shall be the first of the month following loss of coverage, or following determination of eligibility for premium assistance, provided proper enrollment is completed within sixty (60) days of loss of coverage.

**DEPENDENT SPECIAL ENROLLMENT EFFECTIVE DATE** - Newly acquired Dependents of eligible Participants shall be Special Enrollees and eligible to enroll without a Waiting Period if enrollment is requested within thirty (30) days of the following:

1. Birth; or
2. Adoption or placement for adoption; or
3. Marriage.

The effective date of coverage for the above Special Enrollee shall be date of birth, date of adoption or placement for adoption, or date of marriage provided proper enrollment is received within thirty (30) days. The eligible Employee and/or Employee's Spouse of the newly acquired Dependent that are not covered by the Plan shall also be a Special Enrollee eligible to enroll with the newly acquired Dependent. The effective date of coverage will be same as that of one Dependent being added as explained above.

## **TERMINATION OF COVERAGE**

**PARTICIPANT TERMINATION** –Participant Coverage shall automatically terminate immediately upon the earliest of the following dates:

1. At the end of the month in which the Participant's employment terminates; or
2. Date the Participant ceases to be in a class of Participants eligible for coverage; or
3. Date the Participant fails to make any required contribution for coverage; or
4. Date the Plan is terminated; or with respect to any Participant benefits of the Plan, the date of termination of such benefit; or
5. Date the Participant dies.

**DEPENDENT TERMINATION** - The Dependent Coverage of a Participant shall automatically terminate immediately upon the earliest of the following dates:

1. Date the Dependent ceases to be an eligible Dependent as defined in Plan; or
2. Date of termination of the Participant's coverage under the Plan; or
3. Date the Participant ceases to be in a class of Participants eligible for Dependent Coverage; or
4. Date the Participant fails to make any required contribution for Dependent Coverage; or
5. Date the Plan terminated; or with respect to any Dependent's benefit of the Plan, the date of termination of such benefit; or
6. Date the Participant dies.

If the Participant is a Dependent as defined under Domestic Partnership, coverage shall automatically terminate immediately upon the earliest dates as defined by the above Dependent Termination section. In addition, the Participant will be responsible to complete and to file a Declaration of Termination of Domestic Partnership within thirty-one (31) days of termination of the Domestic Partnership.

### **RETIREE TERMINATION**

Coverage for retirees and eligible dependents of retirees will automatically terminate upon the earliest of the following dates:

1. For other dependents, the date that dependent ceases to be an eligible dependent as defined in the Plan or the date that both retiree and spouse are no longer covered by the Plan;
2. The date that the retiree fails to make any required contribution;
3. The date that the Company terminates retiree coverage;
4. The date that the Plan is terminated.

## TERMINATION OF COVERAGE (Cont'd)

**FAMILY AND MEDICAL LEAVE ACT OF 1993** - All previous provisions including Eligibility For Coverage, Effective Date of Coverage, and Termination of Coverage are intended to be in compliance with the Family and Medical Leave Act of 1993 (FMLA), 29 U.S.C. § 2601 *et seq.* To the extent the FMLA applies to the Company, group dental benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements, the obligations of the employer and Employee concerning conditions of leave, and notification and reporting requirements are specified by the FMLA. Any plan provision which conflicts with the FMLA are superseded by the FMLA to the extent such provisions conflict with the FMLA. A Participant with the questions concerning any rights and/or obligations should contact the Plan Administrator or his employer.

**MEDICAL LEAVE OF ABSENCE** - A Participant whose active work ceases because of Illness or Injury shall be considered employed by the Company for the purposes of his coverage under the Plan, and such coverage may continue until the Company, acting in accordance with a policy which precludes individual selection, terminates such coverage, but not beyond the period ending six (6) months after the date that active work ceases because of Illness or Injury. This medical leave of absence provision is subject to the requirements of the FMLA.

**LEAVE OF ABSENCE** - Coverage on a Participant whose active work ceases due to an approved leave of absence granted for reasons other than Injury or Illness and whose employment has not terminated may be continued until the Company, acting in accordance with a policy which precludes individual selection, terminates such coverage, but not beyond the period ending three (3) months after such Leave of Absence began. This continuation during a Leave of Absence neither expands nor limits the requirement of the FMLA.

**TEMPORARY LAYOFF** - A Participant whose active work ceases due to a temporary layoff shall be considered employed by the Company for the purpose of his coverage under the Plan, and such coverage may continue until the end of the month in which the layoff began.

**MILITARY LEAVE ACT** - Notwithstanding anything in this Plan to the contrary, with respect to any Employee Participant or Dependent who loses coverage under this Plan during the Employee's Participant's absence from employment by reason due to a USERRA Leave, no Pre-Existing Condition exclusion or Waiting Period may be imposed upon the reinstatement of such Employee's Participant's or Dependent's coverage upon re-employment of the Employee unless the Pre-Existing Condition exclusion or Waiting Period would have otherwise applied to such Employee Participant or Dependent had the Employee Participant not been on a USERRA Leave.

**PART II**  
**DENTAL CARE BENEFITS**

**RANDALL COUNTY  
DENTAL SCHEDULE OF BENEFITS**

Effective: October 1, 2009

| <b>Dental Expense Benefit</b>   |         |
|---|---------|
| Percentage Payable on Eligible Dental Expenses:   |         |
| Type A Expenses (Preventive or Diagnostic)  | 100%    |
| Type B Expenses (Basic Dental Procedures) and Type C (Major Dental Procedures)<br>If treatment has been performed within last 12 months.            | 70%     |
| Type B Expenses (Basic Dental Procedures) and Type C (Major Dental Procedures)<br>If treatment has <b>not</b> been performed within last 12 months. | 50%     |
| *Type D Expenses (Orthodontics)   | 60%     |
| Plan Year Maximum Benefit (Type D Not Included)   | \$1,000 |
| Plan Maximum Benefit (Type D Expenses)  | \$2,000 |

**\*Orthodontic Treatment is limited to Dependents under nineteen (19) years of age.**

**Waiting Periods for Dental Services:**

|                                   |                    |
|-----------------------------------|--------------------|
| Type A – Preventive or Diagnostic | None               |
| Type B – Basic Dental Procedures  | None               |
| Type C- Major Dental Procedures   | None               |
| Type D – Orthodontics             | Twelve (12) Months |

**ADVANCE CLAIM REVIEW**

When a dentist's treatment plan exceeds \$300, details of the proposed course of treatment and charges should be filed with the Plan Supervisor. The Plan Supervisor will estimate the benefit and notify the dentist of this estimation. Advance Claim Review is not mandatory but is beneficial in helping Covered Participants determine benefits available under the plan prior to having procedures performed.

The Plan Supervisor has the right to require an oral exam of the person at its own expense and provide at request all diagnostic and evaluative material it may require.

## DEFINITIONS

**WHEN THIS BENEFIT APPLIES** - This benefit applies when dental charges are incurred by a covered person while covered under this plan.

**DEDUCTIBLE** - Before benefits can be paid in a Plan year, a covered person must meet the deductible. This is an amount of Dental Charges for which no benefits will be paid. The Deductible is shown in the Schedule of Benefits.

**FAMILY DEDUCTIBLE LIMIT** - When a family reaches the maximum deductible as stated in the Schedule of Benefits, each other covered person in the family will be considered to have met the annual deductible for that Plan year. Family means you and your covered dependents.

**BENEFIT PAYMENT** - Each Plan year, benefits will be paid for the Dental Charges of a covered person that are in excess of the deductible. Payment will be made at the rate shown under "Percentage Payable" in the Schedule of Benefits. No benefits will be paid: (1) in excess of the Maximum Benefit Amount; or (2) for charges incurred for dental services and supplies that are excluded under the Exclusions and Limitations section of the policy.

**BENEFIT WAITING PERIOD** - The Benefit Waiting Period is the period of time that an Employee or Dependent must be covered by the Dental Plan before expenses are eligible for reimbursement. The Benefit Waiting Period for each type of dental charge is stated in the Schedule of Benefits.

**CLOSE RELATIVE** - The term "Close Relative" means the spouse, parent, brother, sister, child or spouse's parent of the Covered Person.

**MAXIMUM BENEFIT AMOUNT** - The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid on each covered person for all Dental Charges in a Plan year.

**DENTAL CHARGES** - These are the reasonable charges made by a dentist or other physician for the necessary care, service, appliance or other dental material that is listed as a Covered Dental Service.

A Dental Charge is incurred on the date that the service or supply for which it is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Plan will apportion that overall charge to each of the separate visits or treatments. The pro-rata charge will be considered to be incurred as each visit or treatment is completed.

## **TYPE A DENTAL EXPENSES**

(Preventive or Diagnostic Services)

The charges included in this category are Preventive, Emergency or Palliative, and some Corrective Surgical Procedures. The charges eligible under Type A are as follows:

1. Routine Oral Examinations – Limited to two (2) per Plan Year.
2. Radiographs and Radiographic Interpretations
  - a. Complete series of Radiographs or Panographic X-rays - Limited to one (1) during any thirty-six (36) month period.
  - b. Sets of Bitewing Radiographs – Limited to two (2) sets per Plan Year.
  - c. Radiographs to diagnose a symptom or examine progress of a particular course of treatment excluding radiographs required for endodontic procedures.
3. Required consultation with another dentist.
4. Prophylaxis - Limited to two (2) treatments per Plan Year.
5. Topical Fluoride applications - Limited to two (2) treatments per Plan Year for Covered Persons under age sixteen (16).
6. Emergency or Palliative Services
7. Diagnostic Tests and Laboratory Examinations excluding X-rays, study models or similar records prepared for orthodontic procedures.
8. Sealants – Limited to two (2) treatments per Covered Person under age fourteen (14).
9. Provisional Space Maintainers for missing Deciduous teeth for children under age fourteen (14).

The above Type A Eligible Dental Expenses are deemed to be incurred:

1. By the person receiving the dental care, and
2. As of the date dental care is performed.

## **TYPE B DENTAL EXPENSES**

(Basic Dental Procedures)

The charges included in this category are Basic Dental Procedures. The charges eligible under Type B services are as follows:

1. Fillings - amalgam, composite, acrylic, or equivalent
2. Removal of Teeth
3. Preformed Stainless Steel Crowns for Deciduous teeth only
4. Endodontics - Root canal therapy and root canal fillings, treatment of disease of the pulp tissue
5. Periodontics - Treatment of disease of the gum and other supporting tissues of the teeth not including splints with cast restorations
6. Oral surgery and related general anesthetic other than:
  - a. Implants and transplants
  - b. Repositioning of the jaw
7. Removal of Impacted Teeth and related anesthesia
8. Injection of antibiotic drugs.
9. Repair or re-cementation of crowns, inlays/onlays, bridgework or dentures.

The above Type B Eligible Dental Expenses are deemed to be incurred:

1. By the person receiving the dental care, and
2. As of the date dental care is performed.

## **TYPE C DENTAL EXPENSES**

(Major Dental Procedures)

The charges included in this category are Major Dental Procedures. The charges eligible under Type C Services are as follows:

1. Inlays, onlays, crowns, and other Gold and baked porcelain restorations (but only when the tooth is damaged beyond restoration by a routine filling).
2. Prosthodontic Services:
  - a. Construction and insertion of bridges or dentures
  - b. Construction and insertion of bridges or dentures to replace teeth previously replaced by an equivalent bridge or denture but generally only if at least five (5) years have elapsed since that previous bridge was initially constructed and inserted.

Construction and insertion of bridges or dentures more often than once in a five (5) year period is not considered as an Eligible Dental Expense unless such becomes necessary because:

    - a. It is needed to replace a bridge or denture which has caused temporomandibular joint disturbances, and which cannot be economically modified to correct the condition, or
    - b. It is needed to replace a denture which was inserted shortly following extraction of teeth and which cannot be economically modified to the final shape required.
    - c. Accidental bodily injury. Such Injury must occur while the Covered Person is Covered Person under the policy. Chewing injuries are not considered accidental bodily injuries.
3. Relining or Rebase of an existing partial or complete Denture more than six (6) months after the denture was installed. Limited to one (1) in any thirty-six (36) consecutive month period.

### **EXPENSES DEEMED INCURRED FOR TYPE C BENEFITS**

Except as provided in (1), (2) and (3) below, any expense or charge for Type C Eligible Dental Expenses will be deemed incurred as of the date the particular procedure is performed.

1. Expenses for fixed bridgework, crowns, inlays or restorations will be deemed incurred on the first date of preparation of the tooth or teeth involved provided you (or your Dependent) remain continuously insured during the course of treatment.
2. Expenses for full or partial dentures will be deemed incurred on the date the final impression is taken provided you (or your Dependent) remain continuously insured during the course of treatment.
3. Expenses for Rebase of an existing partial or complete denture will be deemed incurred on the first day of preparation of the Rebase of such denture provided you (or your Dependent) remain continuously insured during the course of treatment.
4. Benefits paid for temporary service will be deducted from the benefits otherwise payable for the final service. Any temporary prosthetic inserted and utilized by a Covered Person for at least twelve (12) months will be considered permanent in nature and item six (6) of Exclusions will apply.

## **TYPE D DENTAL EXPENSES**

(Orthodontic)

Orthodontic Treatment for dependent children under nineteen (19) years of age consists of appliance, surgical, functional-myofunctional, and other related treatment (including incidental oral examinations) of dental irregularities, which result from abnormal growth and development of teeth, gums, or jaws or as a result of accidental Injury which requires repositioning (except for preventive treatment) of teeth to establish normal occlusion. (Related oral examinations, surgery and extractions included in Type A, B, or C Services).

Limitations of Type D Services:

1. If Orthodontic Treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefits for the services will be resumed to the extent of the remaining lifetime benefit applicable to the covered individual being treated.
2. Payment of benefits for orthodontic services will be only for months in which a person is a Covered Person.
3. Coverage for Type D Services is available only to dependents under nineteen (19) years of age.

A charge is considered incurred as of the date on which the service or supply for which the charge is made is rendered or obtained, except with respect to charges for Orthodontic Treatment.

1. Twenty-five percent (25%) of the total charges for the course of treatment shall be considered as being incurred on the date the initial appliance is inserted; and
2. The remainder of the total charge shall be divided by the number of months proposed by the Dentist or Physician for the course of treatment, and the resulting monthly pro rate portion shall be considered to be incurred as of the first day of each month thereafter.

## DENTAL EXCLUSIONS AND LIMITATIONS

**ELIGIBLE DENTAL EXPENSES** do not include and no benefits are provided for:

1. Charges for any service in excess of the Usual and Customary charge.
2. Procedures not included in the list of Eligible Dental Expenses.
3. Procedures that the Plan Administrator determine to be unnecessary.
4. Procedures that the Plan Administrator determines do not have uniform professional endorsement.
5. Procedures related to the change of vertical dimension, restoration of occlusion, bite registration, bite analysis or periodontal splinting.
6. Charges for replacement of bridges, partial or full dentures;
  - a. If they can, as determined by the Plan Administrator, be satisfactorily repaired and restored to function; or
  - b. If at least five (5) years from the date of initial placement.
7. Implants, lost or stolen appliances, precision or semi-precision attachments, over dentures or customized prostheses, denture duplication, or other customized attachments.
8. Charges incurred for Cosmetic Procedures, including charges for veneers (the coating or covering of plastic or porcelain on the outside of and bonded to a crown or false tooth to cause it to blend with the color of surrounding teeth).
9. The initial placement of partial or full dentures, or bridges if the prosthesis includes the replacement of teeth missing prior to the effective date of the Covered Person's coverage including congenitally missing teeth. This exclusion will not apply if the prosthesis replaces a Functioning Natural Tooth that is extracted by a Dentist while the Covered Person is insured under the policy.
10. Charges for any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are or could be provided under Workers' Compensation.
11. Charges for care, treatment, services or supplies, which are furnished, paid for or reimbursable by any government or subdivision of government. This restriction will not apply;
  - a. To the extent that the Covered Person is required by law to pay such charges;
  - b. To charges incurred by a veteran for non-service connected Eligible Dental Expenses; and
  - c. To charges incurred by retired veterans or Dependents of veterans confined in a military hospital;
12. Dental care resulting from any Injury sustained as a result of war, declared or undeclared, or any action of war or any resistance to armed invasion or aggression or international police action;
13. Failure to keep appointments;
14. Dental care resulting from a self-inflicted Injury, unless the Injury is the result of a domestic violence or medical condition (physical or mental health condition);

## DENTAL EXCLUSIONS AND LIMITATIONS (Cont'd)

15. Dental care resulting from participation in the commission of a felony.
16. Orthodontic treatment except as specified elsewhere in this Plan.
17. Treatment of Temporomandibular joint dysfunction and orthognathic surgery.
18. Dental care resulting from active participation in a riot;

The words "Participation" and "Riot" in the phrase "participation in a riot" will be defined as follows:

Participation - Includes promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but will not include actions taken in defense of public or private property, or actions taken in defense of the person of the Covered Person, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen.

Riot - includes all forms of public violence, disorder, or disturbance of the public peace, by three (3) or more persons assembled together, whether or not acting with a common intent and whether or not damage to person or property or unlawful act or acts is the intent or the consequence of such disorder;

19. Charges made by a Dentist or Dental Hygienist who is a Close Relative.
20. Eligible Dental Expenses incurred while insurance is not in force.
21. Charges for care, treatment, services, or supplies to the extent that any benefit is provided by Medicare.
22. Charges, which are not customarily made when there is no insurance, or charges for which there is no legal obligation to pay.
23. Charges for oral hygiene and a plaque control program or dietary instruction.
24. Charges for postage and handling.
25. Charges by a Physician for contacting a Covered Person by phone, fax or e-mail or charges for ordering a prescription.
26. Charges that have been previously processed (duplicate charges).
27. Charges incurred outside the United States if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies.
28. Treatment other than by a Dentist, except the scaling or cleaning of teeth and topical application of fluoride may be performed by a Dental Hygienist, if the treatment is rendered under the supervision and guidance of a Dentist.
29. Services or supplies furnished through a medical department, clinic or similar facility provided or maintained by the Covered Persons employer, unless the individual is legally obligated to pay the charge.
30. Services or supplies, which are not necessary, according to, accepted standards of dental practice including charges for services or supplies that are experimental in nature.

## **FUNDING**

**COST OF THE PLAN.** Randall County shares the cost of Employee coverage under this Plan with the Covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The covered employees pay the entire cost for coverage for their Dependents. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

## **DENTAL CLAIM PROCEDURES FOR POST SERVICE CLAIMS**

The procedures outlined below must be followed by Covered Persons ("Claimants") to obtain payment of dental benefits under this Plan.

**DENTAL CLAIMS** - All claims and questions regarding dental claims should be directed to the Plan Supervisor. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion the Claimant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Plan Supervisor; provided, however, that the Plan Supervisor is not a Fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Claimant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the Claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

Under the Plan, there is one type of claim: Post-Service. See the section entitled "Definitions" for more details.

### **KEY POINTS TO REMEMBER**

1. All claims for benefits must be filed by the Participant with the Plan Supervisor.
2. It is the Participant's responsibility to see that Physician bills and dental bills get to the Plan Supervisor. Proper payment cannot be made without these bills.

**WHEN DENTAL CLAIMS MUST BE FILED** - Dental claims must be filed with the Plan Supervisor within one-hundred eighty (180) days of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. Claims filed later than that date shall be denied.

A Post-Service Claim is considered filed when the following information is received by the Plan Supervisor, together with the standard claim form used by the provider of service:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. A yearly fully completed, signed and dated W-9 is required from the provider, if the provider accepts assignment;
4. The place where the services were rendered;
5. The diagnosis and procedure codes;
6. The amount of charges;
7. The name of the Plan;
8. The name of the covered employee
9. The name of the patient; and
10. Information on other insurance, if applicable.

## DENTAL CLAIM PROCEDURES FOR POST SERVICE CLAIMS (Cont'd)

Upon receipt of this information, the claim will be deemed filed with the Plan. The Plan Supervisor will determine if enough information has been submitted to enable proper consideration of the claim. If not, the Plan Supervisor must notify the Claimant as to what specific information is needed to process the claim. The Claimant has forty-five (45) days from receipt of the notice to provide the specified information. **Failure to do so may result in claims being declined or reduced.**

The Plan Supervisor will have the right to require any of the following:

1. A complete dental chart showing:
  - a. Extractions
  - b. Missing teeth
  - c. Fillings
  - d. Prosthesis
  - e. Periodontal pocket depths
  - f. The date of any work previously performed.
2. An itemized bill for all dental care.
3. The following exhibits:
  - a. X-rays
  - b. Study models
  - c. Laboratory and/or hospital records

**TIMING OF CLAIM DECISIONS** - The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination within the following timeframes:

1. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension is needed, then prior to the end of the 15-day extension period.
2. If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

**EXTENSIONS** - This initial thirty (30) day processing period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

**CALCULATING TIME PERIODS** - The period of time within which a benefit determination is required, shall begin at the time a claim is deemed filed in accordance with the procedures of the Plan.

**NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION** - The Plan Administrator shall provide a Claimant with a notice either in writing or electronically containing the following information:

1. A reference to the specific portion(s) of the Plan Document upon which a denial is based;
2. Specific reason(s) for a denial;

### **DENTAL CLAIM PROCEDURES FOR POST SERVICE CLAIMS (Cont'd)**

3. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary;
4. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits;
5. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
6. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request);
7. In the case of denials based upon a medical judgment (such as whether the treatment is Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, free of charge, upon request.

If the Claimant believes a claim has been denied wrongly, the Claimant may appeal the denial. See the section entitled "Appeals of Adverse Determinations" for more information.

## **APPEALS OF ADVERSE BENEFIT DETERMINATIONS**

**FULL AND FAIR REVIEW OF ALL CLAIMS** - In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination.

More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination and sixty (60) days to appeal a second Adverse Benefit Determination;
2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate Named Fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
5. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan Fiduciary shall consult with an Appropriate Health Care Professional, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;
6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
7. That a Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits in possession of the Plan Administrator or the Plan Supervisor; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

### **FIRST APPEAL LEVEL**

**REQUIREMENTS FOR FIRST APPEAL** - The Claimant must file the first appeal in writing within one hundred-eighty (180) days following receipt of the notice of an Adverse Benefit Determination.

To file an appeal in writing, the Claimant's appeal must be addressed as follows or faxed to the following number:

For Post Service Claims:

Insurance Management Services  
Customer Service Representative  
P.O. Box 15688  
Amarillo, TX 79105  
(806) 373-6646

## APPEALS OF ADVERSE BENEFIT DETERMINATIONS (Cont'd)

It shall be the responsibility of the Claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Claimant;
2. The Employee/Claimant's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Claimant will lose the right to raise factual arguments and theories which support this claim if the Claimant fails to include them in the appeal;**
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

**TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON FIRST APPEAL** - The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

**Post-Service Claims** - Within a reasonable period of time, but not later than 30 days after receipt of the appeal.

**CALCULATING TIME PERIODS** -The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

**MANNER AND CONTENT OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATION ON FIRST APPEAL** - The Plan Administrator shall provide a Claimant with notification in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Plan Document or Summary Plan Description on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;

## **APPEALS OF ADVERSE BENEFIT DETERMINATIONS (Cont'd)**

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;
6. If the Adverse Benefit Determination is based upon a medical judgment, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided free of charge upon request;
7. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary;
8. A description of the Plan's review procedures and the time limits applicable to the procedures; and

**FURNISHING DOCUMENTS IN THE EVENT OF AN ADVERSE DETERMINATION** - In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

### **SECOND APPEAL LEVEL**

**ADVERSE DECISION ON FIRST APPEAL; REQUIREMENTS FOR SECOND APPEAL** - Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the Claimant has sixty (60) days to file a second appeal of the denial of benefits. The Claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Claimant's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

**TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON SECOND APPEAL** - The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

**POST-SERVICE CLAIMS** - Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.

**CALCULATING TIME PERIODS** -The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

**MANNER AND CONTENT OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATION ON SECOND APPEAL** - The same information must be included in the Plan's response to a second appeal as a first appeal, except for (i) a description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is needed; and (ii) a description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

## **APPEALS OF ADVERSE BENEFIT DETERMINATIONS (Cont'd)**

**FURNISHING DOCUMENTS IN THE EVENT OF AN ADVERSE DETERMINATION** - In the case of an Adverse Benefit Determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

**DECISION ON SECOND APPEAL TO BE FINAL** - If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate Named Fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one (1) year after the Plan's claim review procedures have been exhausted.

**APPOINTMENT OF AUTHORIZED REPRESENTATIVE** - A Claimant is permitted to appoint an Authorized Representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Claimant to a provider will not constitute appointment of that provider as an Authorized Representative. To appoint such a representative, the Claimant must complete a form, which can be obtained from the Plan Administrator or the Plan Supervisor. In the event a Claimant designates an Authorized Representative, all future communications from the Plan will be with the representative, rather than the Claimant, unless the Claimant directs the Plan Administrator, in writing, to the contrary.

## INTERNAL RULES, GUIDELINES OR PROTOCOL

Below are the administrative processes that are used in operating the Plan to satisfy basic fiduciary standards of conduct. These procedures are utilized for consistent decision-making that may or may not result in documents or information that can be disclosed pertaining to an individual claims decision. To receive more information concerning these concepts, free of charge; please make a written request to the Plan Supervisor.

**CLAIMS EDIT SYSTEM** - The Claims Edit System Knowledgebase (referred to as CES) helps identify inappropriate coding relationships and the line item information on provider medical bills. Application of the CES Knowledgebase allows claims processors and adjudicators to identify potentially incorrect or inappropriate coding relationships by a single provider, for a single patient and/or for a single date of service.

CES shows coding relationships for CPT, HCPCS and ICD-9 codes. These three nomenclature and classification systems are the healthcare industry standards used to report procedures, professional/ancillary services, supplies, drugs, anesthesia services, and diagnosis.

Because the practice of medicine is not an exact science, the billing and reimbursement of medical services is a process with many complexities. To construct the multiple edits that are found in the CES Knowledgebase, clinical staff found it necessary to formulate a set of rules in the form of clinical concepts. The clinical concepts are guidelines established specifically and only for the CES Knowledgebase.

**CPT CODE MODIFIER** - The CPT coding system includes two-digit modifier codes, which are used to report that a service or procedure has been “altered or modified by some specific circumstance” without altering or modifying the basic definition or CPT code. Certain modifiers may affect the Usual and Customary fee for that procedure.

**USUAL & CUSTOMARY** – The Plan uses medical pricing data, a pricing approach which combines the use of a relative value scale along with charge data by geozip (geographical area), and/or a percentage of Medicare pricing in calculating Usual & Customary allowances. Relationships between procedures are also used in determining potential allowable charge amounts.

## PRIVACY STANDARDS

### 1. Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

“Summary Health Information” may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

### 2. Disclosure of Protected Health Information (“PHI”) to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);
- b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
- f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
- g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
- h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);
- i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

## **PRIVACY STANDARDS (Cont'd)**

j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

i. The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

Director of Employee Benefits  
Human Resources Director  
Plan Auditor  
Chief Financial Officer  
Any staff designated by one of the above positions.

A complete list may be obtained free of charge from your Plan Sponsor, upon written request.

ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan Administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan Administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

### **3. Disclosure of Certain Enrollment Information to the Plan Sponsor**

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

### **4. Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage**

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

### **5. Other Disclosures and Uses of PHI**

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

## COORDINATION OF BENEFITS (COB)

The following COB Rules shall govern entitlement to benefits notwithstanding any contrary provision in the Plan.

**INTRODUCTION** - The COB Rules provide a claim-payment procedure that may enable a Covered Person to receive, from all dental plans (including government plans) under which the Covered Person is covered, total payments up to but not more than, the full amount of a Covered Expense. Generally, when this Plan is the Primary Plan with respect to a Participant or Dependent, it pays full plan benefits for the claim. When this Plan is the Secondary Plan with respect to a Participant or Dependent, it will pay the amount set forth in the section entitled "Effect On The Benefits Of This Plan" below.

**CASES WHERE THIS PLAN IS SECONDARY PLAN** - When there is a basis for a claim under this plan and under another plan, this Plan is a "Secondary Plan" which has its benefits determined after benefits of the other plan, unless:

1. The other plan has rules coordinating its benefits with Benefits under this Plan; and
2. Both the rules of the other plan and the rules in the section entitled "Ordering Rules" below, require that Benefits under this Plan be determined before benefits under the other plan.

Otherwise, this Plan is "Primary Plan." If this Plan is the Secondary Plan, the other plan will be the Primary Plan. If this Plan is the Primary Plan, the other plan will be the Secondary Plan.

**ORDERING RULES** - This Plan determines its order of benefits using the first (in alphabetical sequence) of the following rules that is applicable:

1. Participant/Dependent - The benefits of the plan that covers the recipient of Covered Services as a Participant are determined before those of the plan that covers the recipient of Covered Services as a Dependent.
2. Child of Parents Not Separated or Divorced - Except as stated in the section entitled "Ordering Rules" subsection (C), below, when this Plan and another plan cover the same child as a Dependent of different persons, called "parents":
  - a. The benefits of the plan of the parent whose birthday falls earlier in a Plan year (month and day) are determined before those of the plan of the parent whose birthday falls later in that year; but
  - b. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the other plan that covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in (1), above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

3. Child of Separated or Divorced Parents - If two or more plans cover a recipient of Covered Services as a child of divorced or separated parents, benefits for the child are determined in this order:
  - a. First, the plan of the parent with custody of the child;
  - b. Then, the plan of the Spouse of the parent with custody of the child; and
  - c. Finally, the plan of the parent not having custody of the child.

## COORDINATION OF BENEFITS (Cont'd)

However, if the terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This section (c) above, does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has such actual knowledge.

4. Active/Inactive Employee - The benefits of a plan which covers the recipient of Covered Services as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a plan which covers such person as a laid off or retired employee (or as that employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, the rule of this subsection (4) is ignored.
5. For a Qualified Beneficiary who has elected Continuation of Coverage under this Plan and is covered under another group insurance arrangement, this Plan will always be considered secondary payor to the other group insurance arrangement.
6. Longer/Shorter Length of Coverage - If none of the above rules determines the order of benefits, the benefits of the plan that covered the recipient of Covered Services longer are determined before those of the plan that covered such person for the shorter time.

**SUBMISSION OF CLAIMS** - Claims should be submitted to the Primary Plan first. Any balance remaining after payment by the Primary Plan should then be submitted to the Secondary Plan. Claims for Covered Services not covered under this Plan will not be considered Covered Expenses even though they are covered under another plan that covers a Participant or a Dependent.

**EXCHANGES OF INFORMATION** - In order to administer the COB Rules, the Benefit Administrator may exchange information about any Claim with the carrier of any other plan that covers a Participant or a Dependent. As part of this process, the Benefit Administrator may require a Participant to provide relevant information.

**EFFECT ON THE BENEFITS OF THIS PLAN** - If this Plan is a Secondary Plan with respect to (and its benefits are determined after those of) one or more other plans, the amount of Covered Expenses for which a Covered Person shall be reimbursed in a Claim Determination Period shall be the lessor of: (a) the Covered Expenses that would otherwise be payable under this Plan in the absence of these COB Rules with respect to an Allowable Expense incurred by the Covered Person during the Claim Determination Period; or (b) the Covered Expenses minus the actual benefits payable by the other plan. When another plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an Allowable Expense and a benefit payable. Amounts payable by this Plan will never exceed the total liability of this Plan. When Covered Expenses of this Plan are reduced in accordance with these COB Rules, each separate Covered Expense shall be reduced in the same proportion and then charged against any applicable benefit limit of this Plan.

**OTHER RULES** - If payment made under another plan includes an amount that should have been paid under this Plan, the Plan Administrator may pay that amount directly to that other plan. Any amount paid under the preceding sentence shall be treated as a Covered Expense paid under this Plan, and such amount shall not be paid again. With respect to benefits provided in the form of services, the amount of a "payable made" shall equal the reasonable cash value of the benefits provided in the form of services.

If the amount of any payment made by this Plan is more than should have been paid under these COB Rules, the Plan may recover the excess from:

1. The Covered Person to whom, or on whose behalf, payment was made;
2. Any insurance company that should have made such payment;
3. Any other plan that should have made such payment;
4. Any service provider to whom such payment was erroneously made;

## COORDINATION OF BENEFITS (Cont'd)

5. Any other individual or entity which should have made such payment or which received the benefit of such erroneous payments.

With respect to benefits provided in the form of services, the amount of payments made shall equal the reasonable cash value of any benefits provided in the form of services.

### DEFINITIONS

1. **ALLOWABLE EXPENSE** - The term "Allowable Expense" means any medically necessary, Usual & Customary item or expense for dental care, which is covered (without regard to any applicable Deductible or Out of Pocket limit) at least in part by this Plan covering the person for whom the claim is made.
2. **CLAIM DETERMINATION PERIOD** - The term "Claim Determination Period" means, with respect to each person subject to these COB Rules, a Plan year; provided, however, that a Claim Determination Period shall not include any part of a Plan year during which such person has no coverage under this Plan or any part of a Plan year before the date these COB Rules or a similar coordination of benefits provision is effective with respect to such person.
3. **PLAN** - The term "Plan" as used herein will mean any plan providing benefits or services for or by reason of medical or dental treatment, and such benefits or services are provided by:
  - a. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis, including but not limited to:
    - i. Hospital indemnity benefits; and
    - ii. Hospital reimbursement-type plans;
  - b. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;
  - c. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
  - d. A licensed Health Maintenance Organizations (HMO);
  - e. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;
  - f. Any coverage under a government program (other than Medicaid), and any coverage required or provided by any statute;
  - g. Group automobile insurance;
  - h. Individual automobile insurance coverage on an automobile leased or owned by the Company;
  - i. Individual automobile insurance coverage based upon the principles of "NO-Fault" coverage. This does not apply to Personal Injury Protection (PIP) coverage in the state of Texas;
  - j. Any plans or policies funded in whole or in part by an employer or deductions made by an employer from a person's compensation or retirement benefits; or
  - k. Labor/management trustee, union welfare, employer organization or employee benefit organization plans.

## COORDINATION OF BENEFITS (Cont'd)

**COORDINATION WITH MEDICARE** - To the greatest extent allowable under applicable law, coverage under the Plan for a Covered Person who is covered under Medicare shall be secondary to coverage of such Covered Person under Medicare. If a Covered Person's coverage under this Plan is secondary to his coverage under Medicare, the benefits payable under this Plan shall be reduced in the manner described in the COB Rules (applying those rules by treating Medicare as another "plan"). If a Covered Person's coverage under this Plan is not permitted to be secondary to his coverage under Medicare that Covered Person shall be reimbursed for Covered Expenses in accordance with this Plan without regard to that Covered Person's coverage under Medicare. Notwithstanding any provision in this section to the contrary, if a Covered Person is covered by Medicare and choose not to be covered by this Plan, coverage under this Plan shall terminate. A Covered Person is considered covered under Medicare for the purpose of the Plan during any period such Covered Person has actual coverage under Medicare or, while otherwise qualifying for actual coverage under Medicare, does not have such coverage solely because he has refused or failed to make any necessary application for Medicare coverage.

**COORDINATION FOR A PARTICIPANT ON CONTINUATION OF COVERAGE** - For a Qualified Beneficiary who has elected Continuation of Coverage under this Plan and is a covered participant under another group insurance arrangement, this group policy will always be considered secondary payor to the other group insurance arrangement.

## **SUBROGATION, REIMBURSEMENT, AND THIRD PARTY RECOVERY PROVISION**

The Plan includes a Subrogation, Reimbursement and Third Party Recovery Provision. When this provision applies is described below:

If a Participant or Dependent has medical expenses as a result of an Injury or accident for which a third party is, or may be, held responsible, the Plan Administrator may make advance expense reimbursements to, or payments on behalf of, such Participant or Dependent, subject to the Plan's subrogation rights. However, before any such reimbursements or payments will be conditionally made, the Participant or Dependent (or the Dependent's legal guardian if the Dependent is a minor) shall execute an agreement that acknowledges and affirms (1) the conditional nature of the reimbursements or payments and (2) the Plan's rights of subrogation, as provided for below. The Plan Administrator, on behalf of the Plan, has the right to pursue any action to enforce its subrogation rights and its reimbursement rights against a third party.

If a Participant or Dependent receives any benefits arising out of an Injury or Illness for which the Participant or Dependent (or the Participant's or Dependent's guardian or estate) has, may have, or asserts any claim or right to recovery against a third party or parties, including but not limited to any party's liability insurance and uninsured/underinsured motorist proceeds, then any payment or payments under this Plan for such benefits shall be made on the condition and with the understanding that this Plan will be reimbursed. Such reimbursement will be made by the Participant or Dependent (or the Participant's or Dependent's guardian or estate) to the extent of, but not exceeding, the total amount payable to or on behalf of the Participant or Dependent (or the Participant's or Dependent's guardian or estate) from: (1) any policy or contract from any insurance company or carrier (including the Participant's or Dependent's insurer) and/or (2) any third party, plan or fund as a result of a judgment or settlement.

As a condition of receiving benefits under this Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision in its entirety and agrees to reimburse the Plan for 100% of the benefits provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. If the Covered Person retains an attorney, then the Covered Person agrees to only retain one who will not assert any common law doctrines that would reduce the Plan's right of recovery, such as the common fund or made-whole doctrines (as such doctrines are defined by the applicable jurisdiction). Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of whether the minor's representative has access or control of any recovery funds.

This Plan will be subrogated to all claims, demands, actions and right of recovery against any entity including, but not limited to, third parties and insurance companies and carriers (including the Participant's or Dependent's Insurer) to the fullest extent permitted by law in the appropriate jurisdiction. The amount of such subrogation will equal the total amount paid under this Plan arising out of the Injury or Illness for which the Participant or Dependent (or the Participant's or Dependent's guardian or estate) has, may have or asserts a cause of action. In addition, this Plan will be subrogated for attorney's fees incurred in enforcing its subrogation rights under this Section.

The Participant or Dependent on behalf of himself (or his guardian or estate) specifically agrees not to do anything to prejudice this Plan's rights to reimbursement or subrogation. In addition, the Participant or Dependent on behalf of himself (or his guardian or estate) agrees to cooperate fully with the Plan and Plan Administrator in asserting and protecting the Plan's subrogation rights.

## **SUBROGATION, REIMBURSEMENT, AND THIRD PARTY RECOVERY PROVISION (Cont'd)**

The Covered Person, on behalf of himself and each beneficiary of a payment made on the Covered Person's behalf, by accepting benefits under this Plan, agrees (1) to sign any documents requested by the Plan including, but not limited to, reimbursement and/or subrogation agreements as the Plan or its agent(s) may request; (2) to furnish any other information as may be requested by the Plan or its agent(s), (3) that this Plan shall first be promptly reimbursed for any payments made to or on the Covered Participant's behalf under the Plan out of any monies recovered as a result of any lawsuit, judgment, order, award, settlement, compromise, arbitration or other arrangement (regardless of whether or not there has been full recovery or such sums are allocated to any particular type of loss, damage or expense), and (4) to include all benefits paid or payable under the Plan in any liability or other claim against a third party. Failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be deemed for reimbursement of expenses paid by the Plan. Any excess after 100% reimbursement of the Plan may be divided up between the Covered Person and their attorney, if applicable. The Covered Person agrees to take no action that in any way prejudices the rights of the Plan.

If it becomes necessary for the Plan to enforce this provision by initiating any action against the Covered Person, then the Covered Person agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Sponsor has the authority to interpret, construe and construct all of the terms and provisions of the Plan in its discretion, and reserves the right to make any changes or determinations, including factual determinations, that it deems necessary or appropriate, including without limitation, reconciling any inconsistency, resolving any conflict and supplying any omission.

If the Covered Person takes no action to recover money from any source, then the Covered Person agrees, by accepting any benefits from the Plan, to allow the Plan Administrator to initiate its own direct action for subrogation or reimbursement on behalf of the Plan.

Finally, the Participant or Dependent on behalf of himself (or his guardian or estate) specifically agrees to notify the Plan Administrator, in writing, whenever benefits are paid under this Plan that arise out of any Injury or Illness that provides or may provide the Plan subrogation rights under this Section within thirty (30) days of the date that the Injury or Illness arises.

Failure to comply with the requirements of this Section by the Participant or Dependent (or his estate or guardian) may, at the Plan Administrator's discretion, result in a forfeiture of benefits under this Plan.

The Plan administrator, on behalf of the Plan, shall have a first and primary lien against the proceeds of any settlement, award or judgment that results from a claim, lawsuit or other action by or on behalf of a Covered Person for whom benefits were paid under the Plan. Notice of the lien is sufficient to establish the Plan's lien against the third party or insurance carrier. The Plan Administrator shall be entitled to (1) deduct the amount of the lien from any future claims payable to or on behalf of the Covered Person if the lien is not promptly repaid or otherwise promptly recovered by the Plan Administrator, or the Covered Person or other claimant fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to the Plan's rights, and (2) to otherwise take any action that the Plan Administrator deems necessary or appropriate, in its discretion, to enforce the Plan's subrogation rights and its reimbursement rights to the full extent possible.

## **CONTINUATION OF COVERAGE**

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") gives certain persons the right to continue their dental care benefits beyond the date that such benefits might otherwise terminate. Continuation of dental coverage under COBRA shall not duplicate coverage continued under any state or other federal law. USERRA also gives certain persons the right to continue their dental care benefits beyond the date that such benefits might otherwise terminate. The continuation coverage under USERRA runs concurrently with any COBRA coverage that a Covered Person would otherwise be entitled to under the law.

### **DEFINITIONS**

As used in this provision, the following terms shall mean:

1. "Entitlement to Medicare" or "Entitled to Medicare" means the Participant has enrolled in either Medicare Part A or Part B.
2. "Qualified Beneficiary" means: (1) A Participant, for termination or reduced hours; (2) A spouse or a dependent child who were covered dependents under the Plan on the day before the Participant's Qualifying Event occurred; or (3) A child who is born to a Participant, or placed with a Participant for adoption, during a period of COBRA continuation coverage.
3. "Qualifying Event" for a Participant, means a loss of coverage due to either (1) A termination of employment for any reason other than gross misconduct or (2) A reduction in hours of employment. "Qualifying Event" for a Dependent means a loss of coverage due to:
  - a. A Participant's termination of employment (for any reason other than gross misconduct) or reduction in hours of employment;
  - b. A Participant's death;
  - c. A spouse's divorce or legal separation from a Participant;
  - d. A Participant's Entitlement to Medicare;
  - e. A dependent child's loss of dependent status under the Plan.

Termination of employment following a Qualifying Event that is a reduction in hours of employment is not a second Qualifying Event entitling the Qualified Beneficiary to an extension of the period of COBRA coverage continuation.

### **BENEFITS AFFECTED BY COBRA**

There are two categories of benefits that may be continued under COBRA.

1. "Core benefits" are Medical Benefits. Any COBRA continuance option must include core benefits for which the person was covered just prior to the COBRA "qualifying event" (an event that qualifies a person for continued coverage under COBRA).
2. "Non-core benefits" include Dental Benefits, Vision Care Benefits and Flexible Spending Accounts under Section 125 (Cafeteria-type) plans.

If the "qualified beneficiary" (a person eligible for COBRA continuance) was covered by these non-core benefits prior to termination, the individual may, but is not required to continue them under COBRA. Which non-core benefits are to be continued will be indicated by the qualified beneficiary at the time of COBRA enrollment.

## CONTINUATION OF COVERAGE (Cont'd)

Life insurance, accidental death and dismemberment benefits, weekly income or long term disability benefits (if a part of the Employer's plan) and dependent care flexible spending accounts are not considered for continuance under COBRA.

**MAXIMUM TIME PERIODS** - Continuation will be available for a qualified beneficiary up to the maximum time period shown in item (1), (2) or (3) below. Combined qualifying events will not continue a beneficiary's coverage for more than thirty-six (36) months beyond the date of the original qualifying event, or when the Qualifying Event is "Entitlement to Medicare", the thirty-six (36) month continuation period is measured from the date of Medicare entitlement.

1. Up to eighteen (18) months (measured from the date of the original Qualifying Event) for a Participant and his covered Dependent(s) when coverage terminates due to reduction of hours worked, or termination of employment for reasons other than gross misconduct. If there is a second Qualifying Event within the initial eighteen (18) month continuation period, coverage may be extended for an additional eighteen (18) months (for a total continuation period of thirty-six (36) months measured from the date of the original Qualifying Event).

**Note:** A Qualified Beneficiary who is disabled and his covered Dependent(s) may have COBRA coverage extended (and an extra fee charged as discussed below) from eighteen (18) months to twenty-nine (29) months, furthermore, even if the disabled individual is a covered minor dependent, his entire Family can extend their COBRA coverage for an additional eleven (11) months provided that:

- a. The Qualified Beneficiary is determined to be disabled under Title II or Title XVI of the Social Security Act either on the date of the Qualifying Event or during the first sixty (60) days of COBRA coverage; and.
- b. The individual notifies the Plan Administrator within sixty (60) days of the Social Security Administration's determination of disability and within the original eighteen (18) month COBRA period that applies to the person.

Qualified Beneficiaries who are disabled under Title II or Title XVI of the Social Security Act must notify the Plan Administrator within 30 days from the date of final determination that they are no longer disabled. Coverage during the additional eleven (11) month extension terminates as of the month that begins more than thirty (30) days after the date of the final determination that the Qualified Beneficiary is no longer disabled.

2. Up to thirty-six (36) months for:
  - a. A covered child who ceases to be an eligible Dependent;
  - b. A covered dependent of a deceased Participant;
  - c. A former covered spouse whose coverage ceases due to divorce or legal separation; or
  - d. A covered dependent when the Participant's coverage ceases due to eligibility for Medicare.
3. There is a special continuation period for retired Participants and their Dependents when the Employer declares bankruptcy under Title 11 of the United States Code and the retired Participants and their Dependents lose substantial coverage within one (1) year before or after the date the bankruptcy proceedings commenced. Coverage will be continued for each person until the date of the covered retired Participant's death. However, the surviving spouse or children of a deceased retired Participant may continue coverage for up to a maximum of thirty-six (36) months following the retired Participant's death. For this item C, coverage does not terminate when the person becomes eligible for Medicare.

## CONTINUATION OF COVERAGE (Cont'd)

Continued coverage may also cease before the end of the maximum period on the earliest of:

- a. The date that the Employer ceases to provide a group dental plan to any Employee; or
- b. The date that the Qualified Beneficiary first becomes, after the date of election, (a) covered under any other group dental plan (as an Employee or otherwise), or (b) Entitlement to Medicare (except as stated in item C above). However, a Qualified Beneficiary who becomes covered under a group dental plan which has a Pre-Existing Conditions limit must be allowed to continue COBRA coverage for the length of a pre-existing condition or to the COBRA maximum time period, if less. Effective January 1, 1997 the COBRA law has been amended which provides that if a person has COBRA coverage and becomes covered under another group plan that has a Pre-Existing Condition provision that is offset by prior coverage credits, then COBRA coverage can be terminated because the person is covered under another group plan and has satisfied the Pre-Existing Condition provision with prior coverage credits.

**COBRA COVERAGE** - Except as provided below, if the initial coverage election and required contribution payments are made timely, as described in this Section, coverage under the Plan is reinstated retroactive to the date of the Qualifying Event. If a Qualified Beneficiary waives COBRA coverage, he may revoke the waiver at any time during the election period. The Qualified Beneficiary would be eligible for continuation of coverage prospectively from the date that the waiver is revoked, if all other requirements, such as timely contribution payments, are met. A new spouse, a newborn child or a child placed with a Qualified Beneficiary for adoption during a period of COBRA continuation coverage may be added to the Plan according to the enrollment requirements for dependent coverage under the section of this Plan entitled "Eligibility for Coverage." A Qualified Beneficiary may also add new dependents during an open enrollment period held once each year at a time and in accordance with the procedures established by the Plan Administrator. Any election by an employee or his spouse shall be deemed to be an election by any other Qualified Beneficiary, though each Qualified Beneficiary is entitled to an individual election of continuation coverage.

**COBRA CONTRIBUTIONS** - The entire cost (plus a reasonable administration fee) must be paid by the continuing person. Coverage will end if the covered individual fails to make timely payment of contributions or premiums. The first contribution or premium is due within forty-five (45) days of the covered individual's initial COBRA election. All other contributions or premiums must be paid within thirty (30) days of the due date. The Plan Administrator will notify a Qualified Beneficiary of the amount of the required contribution payment and the contribution payment options available. The Qualified Beneficiary must pay premiums for any period of continuation coverage equal to one hundred two percent (102%) of the applicable premium, as defined under and determined in accordance with applicable law. However, any Qualified Beneficiary, including all family members of the disabled individual who are Qualified Beneficiaries entitled to extended coverage under this Section, shall be required to pay premiums equal to one hundred fifty percent (150%) of the applicable premium for the coverage period following the initial eighteen (18) month period.

**NOTICE REQUIREMENTS** - To continue dental coverage, the Plan Administrator must be notified of a Qualifying Event. When coverage terminates due to a Participant's death, termination of employment or reduction in hours or eligibility for Medicare, the Employer has thirty (30) days from the Qualifying Event in which to notify the Plan Administrator of the qualifying event. When coverage terminates due to divorce, legal separation or change of Dependent status, the Qualified Beneficiary has sixty (60) days from the Qualifying Event or from the date coverage terminates in which to notify the Plan Administrator that the Qualifying Event has occurred.

## CONTINUATION OF COVERAGE (Cont'd)

Complete instructions on how to elect continuation will be provided by the Plan Administrator within fourteen (14) days of receiving notice of the qualifying event. Covered Persons then have sixty (60) days in which to elect continuation. The sixty (60) day period is measured from the later of the date coverage terminates or the date notice of the right to continue is sent. If continuation is not elected in that sixty (60) day period, then the right to elect continuation ceases.

**PERSONS ON USERRA LEAVE** - Any Participant who is absent from active employment on a USERRA Leave (and any covered Dependent of such Participant) may elect to continue coverage under this Plan for up to twenty-four (24) months. If the Covered Person elected to continue coverage under USERRA before December 10, 2004, the maximum period for continuing coverage is eighteen (18) months. To continue coverage, the Participant must comply with the terms of the Plan, and pay any required contributions. USERRA also requires regardless of whether continuation of coverage was elected, that coverage be reinstated immediately upon return to employment, so long as the Covered Person Complies with the requirements set forth under USERRA.

The cost of continuing coverage will be:

1. For leaves of thirty (30) days or less, the same as the contribution required from similarly situated Participants;
2. For leaves of thirty-one (31) days or more, up to 102% of the contribution required from similarly situated Participants and the Participating Employer.

Note: For complete information regarding your rights under USERRA, contact your Participating Employer.

## GENERAL PROVISIONS

**EXAMINATION** - The Company shall have the right and opportunity to have the Covered Person examined whose Injury or Illness is the basis of a claim hereunder when and so often as it may reasonably require during pendency of claim hereunder.

**RIGHTS OF RECOVERY** - Whenever payments have been made by the Company with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the Company shall have the right, exercisable alone and in its sole discretion, to recover such excess payments.

**FREE CHOICE OF DENTIST** - The Covered Person or covered Dependent shall have free choice of any legally qualified Dentist or surgeon and the Dentist-patient relationship shall be maintained. Dentist's and other dental care providers are not agents of the Employer, the Plan Administrator or the Plan Supervisor. The actual provision of medical and other services on behalf of any Covered Person remains the sole prerogative and responsibility of the attending Dentist or other dental care service provider.

**WORKERS' COMPENSATION NOT AFFECTED** - This Plan does not take the place of, and does not affect any requirement for coverage by Workers' Compensation Insurance.

**CONFORMITY WITH LAW** - If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

In the event any provision of this Plan conflicts with the Non-Discriminatory Rules of HIPAA, the Plan shall be deemed to be automatically amended so that it is in compliance with the Non-Discriminatory Rules and HIPAA.

**STATEMENTS** - In the absence of fraud, all statements made by a Covered Person will be deemed representations and not warranties. No such representations will void the Plan benefits or be used in defense to a claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such Covered Person.

**MISCELLANEOUS** - Section titles are for conveniences of reference only, and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of this Plan.

## NOTICE OF ENROLLMENT RIGHTS

If an Employee declines enrollment for himself or his Dependents (including his spouse) because of other dental insurance coverage, he may in the future be able to enroll himself or his Dependents in this Plan, provided that he request enrollment within thirty (30) days after the other coverage ends. In addition, if an Employee has a new Dependent as a result of marriage, birth, adoption or placement for adoption, the Employee may be able to enroll himself and his Dependents, provided that he requests enrollment within thirty (30) days after the marriage, birth, adoption or placement for adoption.

## ADMINISTRATIVE INFORMATION

**NAME OF PLAN:** Dental Benefit Plan for the Employees of Randall County

**SPONSORING EMPLOYER ADDRESS:** 400 16<sup>th</sup> Street, Suite B100  
Canyon, Texas 79105

**SPONSOR'S EMPLOYER IDENTIFICATION NUMBER:** 75-6001120

**SPONSOR'S TELEPHONE NUMBER:** (806) 477-1701

**PLAN ADMINISTRATOR:** Randall County

**ADDRESS:** 400 16<sup>th</sup> Street, Suite B100  
Canyon, Texas 79105

**ADMINISTRATOR'S TELEPHONE NUMBER:** 806-477-1701

**AGENT FOR SERVICE OF LEGAL PROCESS:** The Plan Administrator at the address above.

**TYPE OF ADMINISTRATION:** Contract administration. The Plan is administered by a third party administrator.

**PLAN NUMBER:** 502

**PLAN YEAR:** A Plan Year beginning October 1 and ending September 30.

**PLAN SUPERVISOR'S ADDRESS:** Insurance Management Services  
P.O. Box 15688  
Amarillo, Texas 79105  
[www.imstpa.com](http://www.imstpa.com)

**PLAN SUPERVISOR'S TELEPHONE NUMBER:** (806) 373-5944 or (800) 687-5944