NORTHWEST SUBURBAN SPECIAL EDUCATION ORGANIZATION

(NSSEO)

DENTAL PLAN DOCUMENT

This Plan Document has been prepared for review by the undersigned Client and its legal counsel.

Each provision, each benefit, each page in this Plan Document for which the pages are dated January 1, 2000 has been reviewed and approved by the undersigned.

Any changes in this Document shall be made by written Amendment.

Client Name:	Northwest Suburban Special Education Organization (NSSEO)
Approved By:	
Date:	12/21/99

NORTHWEST SUBURBAN SPECIAL EDUCATION ORGANIZATION

(NSSEO)

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This Plan Document becomes effective as of January 1, 2000.

WHEREAS, the Northwest Suburban Special Education Organization (NSSEO) desires to establish a plan to maintain dental benefits for its employees who are beneficiaries of the Plan, it therefore creates and establishes the Northwest Suburban Special Education Organization (NSSEO) Dental Care Plan, hereinafter referred to as the "Plan" and this document thereinafter referred to as the "Plan Document."

Purpose

The purpose of this Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement for all or a portion of covered dental expenses.

Benefits of this Plan shall be payable for expenses incurred on the effective date of this Plan Document, and after, except as specified.

This Plan Document supersedes all other Prior Plan Documents and issued amendments and shall be the sole document used in determining benefits for which Covered Persons are eligible and may be amended from time to time by the Plan Administrator to reflect changes in benefits or eligibility requirements. It is not in lieu of and does not affect any requirements for coverage by Workers' Compensation. Any change so made shall be binding on each Covered Person and on any other individual or individuals referred to in this Plan Document.

Wherever used in this Plan Document, masculine pronouns shall include both masculine and feminine genders and the singular shall include the plural unless the context indicates otherwise.

The fiscal records for the Plan are kept on a plan year basis ending on each December 31st.

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SECTION 1 -- DEFINITIONS

The term **Employer** means the Northwest Suburban Special Education Organization (NSSEO).

The term **Plan Administrator** means the Northwest Suburban Special Education Organization (NSSEO).

The term **Claims Administrator** means Gallagher Benefit Administrators, Inc.

The terms **Accident** and **Accidental** mean an unforeseen or unexplained sudden occurrence by chance, without intent or volition.

The terms **Active Work** and **Actively at Work** as used in this Plan Document mean active full-time performance of all customary duties of his occupation at any location of business to which the Employer requires the Participant to travel. A Participant shall be deemed "Actively at Work" on each day of a regular paid vacation, and on a regular nonworking day on which he is not disabled, provided he was "Actively at Work" on the last preceding working day.

The term **Appliance** as used in this Plan Document means a device used to replace missing parts, to provide function or for therapeutic purposes. The term includes dental prostheses, splints, orthodontic appliances and obturators.

The term **Calendar Year** means that period of time beginning on the first day of January in any Calendar Year and ending on the last day of December in the same Calendar Year.

The term **Covered Person** means a Participant or his Dependent who has enrolled for coverage under this Plan. Covered Person also means an individual having Plan coverage under the Plan's Continuation of Benefits provisions.

The term **Dental Service** means a professional dental service which is included in the list of dental services under Covered Dental Expenses and is rendered by a dentist in the necessary treatment of Accidental Injury, dental disease or defect. It shall also mean:

1. the scaling and cleaning of teeth by a licensed dental hygienist or dental assistant if performed under the supervision and direction of a dentist and a charge is made for such service by the dentist;

2. laboratory services for preparation of dental restoration and dental prosthetic devices if the dentist includes the cost of such services or devices in the charges for these services.

The term **Dependent** means an individual that meets the eligibility requirements described under Section 2 of this Plan to become a Covered Person eligible to receive Dependent Benefits.

The term **Dependent Benefits** means the coverage provided under this Plan Document with respect to a Covered Person who is a Dependent of a Participant.

The term **Endodontics** means the branch of dentistry concerned with the treatment of teeth having damaged pulp; root canal therapy.

The term **Family Member** means a Participant or his Dependent. Under any benefit section, a "covered family member", as of any given time, is a Family Member for whom coverage is then in force under the section.

The term **Incurred Charge** means the charge for a service or supply is considered to be incurred on the date it is furnished except:

1. Expenses for fixed bridgework, crowns, inlays or restorations shall be deemed incurred on the first date of preparation of the tooth or teeth involved provided the person remains continuously covered during the course of treatment.

2. Expenses for full or partial dentures shall be deemed incurred on the date the final impression is taken provided the person remains continuously covered during the course of treatment.

3. Expenses for relining or rebasing of an existing partial or complete denture shall be deemed incurred on the first day of preparation of the reline or rebase of such denture provided the person remains continuously covered during the course of treatment.

4. Expenses or charges for endodontic services shall be deemed incurred on the date the specific root canal procedure commenced provided the person remains continuously covered during the course of treatment.

5. Expenses or charges for orthodontic services shall be deemed incurred on the date the initial active appliance was installed.

The term **Injury** means trauma or damage to the body by an outside force occurring while the individual is a Covered Person and which results in loss covered by the Plan.

The term **Necessary Service or Supply** means a service or supply broadly accepted by the dental profession as essential to the care or treatment of the teeth and/or surrounding tissues and structures.

The term **Oral Surgery** means the branch of dentistry concerned with surgical procedures in and about the mouth and jaws.

The term **Orthodontics** means the branch of dentistry concerned with the detection, prevention and correction of abnormalities in the positioning of the teeth in their relationship to the jaws. Commonly, straightening teeth.

The term **Palliative** means an alleviating measure. To relieve.

The term **Periodontics** means the science of examination, diagnosis and treatment of diseases affecting the periodontium.

The term **Participant** means an employee who meets the eligibility criteria described under Section 2 of this Plan to become a Covered Person eligible for Personal Benefits.

The term **Periodontium** means collectively the tissues which surround and support the tooth: the gingiva, the cementum, the periodontal membrane, and the alveolar or supporting bone.

The term **Personal Benefits** means coverage provided under this Plan Document with respect to a Covered Person who is enrolled not as a Dependent.

The term **Physician** means a medical doctor or surgeon (M.D.), an osteopath (D.O.), or a dentist or dental surgeon (D.D.S., D.M.D.), who is licensed as required by the law of the state in which he practices or, in the absence of such law, recognized by the state association.

The term **Physician Visit** means a personal interview between the patient and a Physician and does not include telephone calls or interviews in which the Physician does not see the patient for treatment.

The term **Prior Coverage** or **Prior Plan** means any plan or policy of group accident and health benefits provided by the Employer (or its predecessor) which has been replaced by coverage under this Plan Document.

The term **Reasonable and Customary** means the charge made by a Physician or supplier of services, medicines, or supplies which does not exceed the general level of charges made by others rendering or furnishing like services, medicines, or supplies, within an area in which the charge is incurred for Sickness or Injury comparable in severity and nature to the Sickness or Injury being treated. The term area, as it would apply to any particular service, medicine, or supply, means a county or such greater area as is necessary to obtain a representative cross-section of level of charges.

The term **Total Disability** means the Participant is unable, as a result of Sickness or Injury, to perform the normal duties of his occupation and is not performing work of any kind for wage or profit.

The term as it applies to a Dependent means the Dependent is unable, as a result of Sickness or Injury, to perform the normal duties appropriate to a person in good health of the same sex and age; and it means a Dependent child is confined in a hospital or extended care facility.

The term **Trust** means any trust established by the Employer as a funding vehicle for the benefits provided by this Plan.

The term **Trustee** means the person, firm, corporation, or other entity appointed by the Employer to manage the Trust.

SECTION 2 -- ELIGIBILITY

PARTICIPANT

An active full-time employee, who is directly employed in the regular business of and compensated for services by the Employer and regularly works 31 or more hours a week; or

A retired or disabled employee who is fully qualified for immediate receipt of IMRF retirement or disability benefits under Article 7 of the Illinois Pension Code on the date of retirement or disability, and who was covered under this Plan on the date immediately prior to that date.

Part-time or temporary employees cannot be considered Participants.

An employee who elects any other dental plan option which may be offered by the Employer cannot be considered a Participant and cannot be covered for benefits under this Plan.

ELIGIBILITY DATE

A Participant hired on or after the effective date of this Plan becomes eligible for Personal Benefits after completing a waiting period of one month continuous employment.

DEPENDENT

Participant's spouse (unless legally separated); and

Participant's unmarried child from birth to the date he attains age 19.

Participant's unmarried child at least 19 years of age to the date he attains 23 years of age provided the child is a full-time student in an accredited school and is principally dependent (named as an exemption on the Participant's most current Federal Income Tax Return) on the Participant for his support and maintenance.*

Participant's unmarried child already covered under the plan, who, from the date his coverage would otherwise terminate under the Plan, is both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) principally dependent (named as an exemption on the Participant's most current Federal Income Tax Return) upon the Participant for support and maintenance* (see Section 5).

A "child" is the Participant's:

- natural born child or legally adopted child. An adopted child shall be considered a "child" from the moment the child is placed in the custody of the parents for adoption; or

- a stepchild or any child who resides in the Participant's household in a regular parent-child relationship and is principally dependent (named as an exemption on the Participant's most current Federal Income Tax Return) on the Participant for support and maintenance*.

*(Proof may be required.)

If both parents of a child are covered for Personal Benefits, either but not both may cover the child as a Dependent.

Any individual who is eligible as a Participant is not a Dependent.

ELIGIBILITY. Each Participant becomes eligible to cover his Dependents for Dependent Benefits on the later of the following dates:

1. the date he is eligible for Personal Benefits, if he then has a Dependent (spouse and/or child); and

2. the date he acquires an eligible Dependent through marriage, birth, adoption, or otherwise as stated above.

If a Participant's Dependent is employed and covered under the NSSEO group plan the day immediately following the date such coverage terminates due to the termination of the Dependent's employment may also be deemed to be the date the Participant first acquires that Dependent and any other Dependent covered under such group plan or plans.

SECTION 3 -- EFFECTIVE DATES

PARTICIPANT

Personal Benefits are noncontributory.

The coverage under this Plan Document for Personal Benefits is noncontributory (Participant does not contribute toward the cost) and becomes effective on the date eligible, provided the Participant has enrolled.

If the Participant does not want to be covered for Personal Benefits, he must sign a waiver of benefits form.

Dual Option Transfer

If a Participant is a member of any other dental option sponsored by the Employer, and he chooses to transfer coverage from the other dental option to this dental plan, he must wait until the annual open enrollment period held during the month of September. Coverage will be effective on the subsequent October 1st. The Late Enrollment provision will not apply.

Late Enrollment

If the Participant does not enroll within 31 days after the date he becomes eligible, that Participant will not be covered until a signed enrollment form is received by the Employer. Coverage will be effective on the date specified by the Employer or Plan Administrator. No benefits will be payable for Major Services or Orthodontia for six months following such late enrollment.

Special Enrollment

If a Participant declines coverage under this Plan when first eligible to enroll because he had other health coverage, including COBRA Continuation Coverage, and he loses the other health coverage, he may enroll for coverage within 31 days of the occurrence. Coverage will be effective on the date of the occurrence.

If a Participant acquires a Dependent through marriage, he may enroll for coverage within 31 days of the marriage. Coverage will be effective on the date of the marriage.

If a Participant acquires a Dependent through birth, adoption or placement for adoption, he may enroll for coverage within 31 days of the birth, adoption or placement for adoption. Coverage will be effective on the date of the acquisition.

DEPENDENT

Dependent Benefits are contributory.

When a Participant enrolls his Dependents and authorizes any required contributions for Dependent Benefits, Dependent Benefits will become effective as follows:

- If a Participant has eligible Dependents on the effective date of his coverage and he has enrolled and authorized contributions for Dependent Benefits on or prior to the Participant's effective date, then coverage for those Dependents will be effective on the date the Participant's coverage begins.

- If a Participant does not have eligible Dependents on the effective date of his coverage and later acquires an eligible Dependent(s) as defined in Section 2 of this Plan Document, and if he enrolls and authorizes any required contributions for Dependent Benefits on or prior to the date of acquisition, then coverage for the Dependent(s) will be effective on the date of acquisition

- If a Participant enrolls for Dependent Benefits within 31 days after the date eligible, then Dependent coverage will be effective on the date the enrollment form is signed. However, coverage will be retroactive to the date of birth if the Participant's eligible Dependent is a newborn.

If the Participant is already enrolled for Dependent Benefits, then Dependent Benefits for a newly acquired Dependent will become effective on the date of acquisition.

Dependent Benefits will not become effective for the Dependents of a Participant unless he is covered, or simultaneously becomes covered, for Personal Benefits.

No individual may be covered simultaneously both as a Participant and as a Dependent.

Late Enrollment

If the Participant does not enroll his Dependents within 31 days after the date they become eligible, those Dependents will not be covered until a signed enrollment form is received by the Employer. Coverage will be effective on the date specified by the Employer or Plan Administrator. No benefits will be payable for Major Services or Orthodontia for six months following such late enrollment.

Special Enrollment

If a Participant declined coverage for his Dependents under this Plan when first eligible to enroll because his Dependents had other health coverage, including COBRA Continuation Coverage, and they lose the other health coverage, he may enroll for Dependent Benefits within 31 days of the occurrence. Coverage will be effective on the date of the occurrence.

If a Participant acquires a Dependent through marriage, he may enroll for Dependent Benefits within 31 days of the marriage. Coverage will be effective on the date of the marriage.

If a Participant acquires a Dependent through birth, adoption or placement for adoption, he may enroll for Dependent Benefits within 31 days of the birth, adoption or placement for adoption. Coverage will be effective on the date of the acquisition.

SECTION 4 -- TERMINATION OF COVERAGE

PARTICIPANT. The coverage of any Participant covered under this Plan Document will cease on the earliest of the following dates except as provided in Section 5 -- Continuation of Benefits (if applicable):

1. The date this Plan Document terminates.
2. The date ending the period for which any required contributions (if required) have been paid.
3. The date he is no longer eligible for coverage under this Plan Document.
4. The date he begins active duty in the Armed Forces of any country for longer than two weeks.
5. The date of death.
6. Thirty days following the date his employment terminates, or August 31st of the school year should he fail to report for duty at the start of the current school year.
7. Retirement, except as indicated below.
8. The date he elects in writing that termination of coverage occurs.

Cessation of active work will result in termination of coverage, except that:

If a Participant is absent from work because of sickness or Injury, his coverage may be considered to continue until terminated by the Employer, provided the Participant makes any required contributions;

If a Participant is absent from work because of temporary layoff or suspension of the Employer's business operations, his coverage may be considered to continue until terminated by the Employer, but for no longer than the end of the second month after the calendar month in which the layoff started, provided the Participant makes any required contributions;

If a Participant is absent from work because of approved leave of absence, his coverage may be considered to continue until terminated by the Employer, but for no longer than 12 months from the date the leave started, provided the Participant makes any required contributions;

With respect to a retired/disabled employee receiving IMRF benefits pursuant to the Illinois Pension Code, coverage may be considered to continue until the Participant is no longer eligible for such pension benefits, provided the Participant makes any required contributions.

An Employer must signify an employee's termination of employment or other event terminating coverage by notifying Gallagher Benefit Administrators, Inc. in writing.

If subsequent to termination of service, a Participant is reemployed or reinstated as an eligible Participant, he will be treated in the same manner as a new Participant at the date of such reemployment or reinstatement.

DEPENDENT. Coverage with respect to **each** Dependent covered under this Plan Document shall cease on the earliest of the following dates:

1. The date such individual ceases to be a Dependent as defined in this Plan Document.
2. The date the Dependent begins active duty in the Armed Forces of any country for longer than two weeks.
3. The date the Dependent becomes eligible under the Plan as a Participant.

Coverage with respect to *all* Dependents of a Participant covered under this Plan Document shall cease on the date the Participant's benefits terminate, except as provided in Section 5, Continuation of Benefits. A Participant's Dependents' benefits shall also terminate on the date the Participant requests such coverage be terminated, but in no event prior to the date of such request.

* * *

When coverage of a Participant and/or Dependent terminates, benefits shall not be provided for any services after termination even though such services are furnished as a result of a sickness or Injury occurring before such termination of coverage unless otherwise provided under the Extended Benefit Provisions.

SECTION 5 -- CONTINUATION OF BENEFITS

(As Required By Federal Law)

Federal Legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that a Participant and/or Dependent may elect to continue coverage up to the length of time specified below after the occurrence of any of the following events which would normally result in termination of coverage under the Plan, provided any required contributions are paid.

Coverage may be continued up to 18 months for a Participant and/or Dependent in the event of the termination of employment (other than by reason of gross misconduct) or the reduction of hours of a Participant.

Continuation coverage may extend from 18 months to 29 months for a Participant and/or Dependent who is or becomes totally disabled (as determined by the Social Security Administration) at any time during the first 60 days of COBRA continuation coverage, provided that such Participant and/or Dependent has given notice of the disability within 60 days of the Social Security determination and requested the extended continuation period before the end of the first 18 months.

Coverage may be continued up to 36 months for a Dependent in the event of:

1. The death of the Participant;

2. The divorce or legal separation of the Participant from his/her spouse;

3. The Participant becomes entitled to Medicare, and as a result he and his Dependents are no longer considered eligible for coverage under the Plan;

4. A Dependent child ceases to be a Dependent under the terms of this Plan.

Coverage will be continued only for those Participants and/or Dependents who were covered under the Plan on the day immediately preceding termination. However, if a child is born or placed for adoption with the Participant during the period of COBRA continuation coverage, such child is entitled to receive COBRA continuation coverage with independent COBRA rights.

Coverage will not be continued beyond the earliest of the following dates:

1. The date ending the period for which any required contribution has been paid (within the grace period);

2. The date the Participant and/or Dependent first becomes entitled to Medicare, or first becomes covered under another group health plan and is not subject to that plans preexisting limitations;

3. The date the Employer ceases to provide any group health plan.

This section shall not apply to such Participants or Dependents for whom a greater period of continuation is provided elsewhere in this Plan Document.

Conformity with the Law

If any provision of this Section is contrary to the Consolidated Omnibus Reconciliation Act of 1985 (as amended), the provision is changed to comply with the law.

Family Security Benefits -- Any Dependent Benefits which are in effect under this Plan at the time of the Participant's death will be continued after such death while any required contributions for such coverage are continued.

However, Dependent Benefits will not be continued beyond the earliest of the following occurrences:

The end of a 90 day period after the Participant's death.

Termination of Dependent Benefits under the Plan.

The end of the period for which contributions (if required) have been paid.

As to the Participant's spouse only, when the spouse remarries or becomes eligible for other coverage.

As to the Participant's Dependent child only, when the child ceases to meet the definition of a Dependent or becomes eligible for other group health coverage.

However, in addition to the above, and only with respect to the surviving spouse of a retired/disabled employee who was receiving IMRF benefits pursuant to the Illinois Pension Code, coverage will be continued during that spouse's lifetime provided the spouse is receiving pension benefits pursuant to the Illinois Pension Code.

Dependent Benefits may be provided under this Plan to a Participant's Dependent child, born after the Participant's death, as long as coverage for his other Dependents is being continued under this section.

For the purposes of filing proof of loss and payment of claims, the Participant's spouse, if living, will be considered as the Participant, otherwise the Dependent child (or his legal guardian) claiming benefits will be so considered.

This Section will not apply to a Dependent for whom a greater period of continuation of coverage is provided elsewhere in this Plan Document.

Coverage For Mentally Retarded and/or Physically Handicapped Dependent Children -- Any Dependent Benefits under this Plan for an unmarried Dependent child, already covered under the Plan, may be continued beyond the date the child attains the limiting age for Dependent children, if **all** the following tests are met:

- On the date the child attains the limiting age, he is incapable of self-sustaining employment because of mental retardation or physical handicap which is objectively verifiable by medical tests.
- The child, on that date, is chiefly dependent on the Participant for support.
- Due proof of the mental retardation or physical handicap is furnished to the Employer not later than 31 days after the date the child attains the limiting age.

However, Dependent Benefits for the child may not be continued beyond the earliest of the following:

- cessation of the physical handicap;
- failure to furnish any required proof of mental retardation and/or physical handicap or to submit to any required examination;
- termination of Dependent Benefits for the child for any reason other than attaining the limiting age.

The Employer will have the right to require due proof of the continuation of the mental retardation and/or physical handicap and will have the right and opportunity to examine the child whenever the Employer may reasonably require it during such continuation. After two years have elapsed from the date the child attained the limiting age, only one examination will be required per year.

SECTION 6 -- COORDINATION OF BENEFITS PROVISIONS

The provisions of this Section (herein called these provisions) are for coordination of all benefits under this Plan Document with other benefits.

DEFINITION OF WORDS AND TERMS USED IN THIS SECTION: The word "Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by:

1. any group, franchise, hospital or medical service, prepayment or other coverage arranged through any employer, trustee, union, employee benefit or other employee association;

2. any coverage under governmental programs, and any coverage required or provided by any statute;

3. any coverage sponsored by, or provided through, a school or other educational institution.

The word **Plan** shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

The term **this Plan** means those Sections of this Plan Document which provide the benefits that are subject to these provisions.

The term **Allowable Expense** means any necessary, Reasonable and Customary item of expense, or such other item of expense at least a portion of which is covered under at least one of the Plans covering the individual for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

The term **Claim Determination Period** means, for any individual, that portion of a Calendar Year during which he would be eligible to receive benefits under this Plan Document in the absence of this Section.

EFFECT ON BENEFITS: These provisions shall apply in determining the benefits as to an individual covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such individual during such period, the sum of:

1. the benefits that would be payable under this Plan in the absence of these provisions, and

2. the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to these provisions

would exceed such Allowable Expenses.

As to any Claim Determination Period with respect to which these provisions are applicable, the benefits that would be payable under this Plan in the absence of these provisions for the Allowable Expenses incurred as to such individual during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in the next paragraph, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been fully made therefor.

1. If another Plan which is involved in the preceding paragraph and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and

2. if the rules set forth in the next paragraph would require this Plan to determine its benefits before such other Plan;

then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.

For the purpose of these provisions, the rules establishing the order of benefit determination are:

1. the benefits of a plan which does not contain Coordination of Benefits provision always shall be determined before the benefits of the plan which does contain a Coordination of Benefits provision;

2. the benefits of a plan which covers the individual on whose expense claim is based other than as a dependent shall be determined before the benefits of a plan which covers such individual as a dependent;

   however, the benefits of a plan which covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before those of a plan which covers that person as a laid off or retired employee or as that employee's dependent;

3. the benefits of a plan which covers a person as an employee who is neither laid off nor retired or a Dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

4. the benefits of a plan covering the child as a Dependent of the father shall be determined before the benefits of a plan covering the child as a Dependent of the mother;

5. if the parents are divorced or legally separated, it is necessary to determine if there is a court decree which establishes financial responsibility for medical, dental or other health care expenses for the child. If there is such a decree, the benefits of the plan covering the parent who has that responsibility shall be determined before the benefits of the plan covering the other parent;

6. if there is no such decree, the benefits of the plan covering the parent who has custody of the child shall be determined before the benefits of the plan covering the other parent;

7. if there is no such decree and the parent with custody of the child has remarried, the order of priority is:

   - the plan covering the parent who has custody;
   - the plan covering the spouse of the parent who has custody, (that is, the stepparent of the child) and;
   - the plan covering the parent without custody.

8. when rules (1) through (7) in this paragraph do not establish an order of benefit determination, the benefits of a plan which has covered the individual on whose expense claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such individual for the shorter period of time.

When these provisions operate to reduce the total amount of benefits otherwise payable as to an individual covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of these provisions shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: For the purpose of determining the applicability of and implementing the terms of these provisions under this Plan or any provision of similar purpose of any other Plan, the Employer may, without the consent of or notice to any individual, release to or obtain from any insurance company or other organization or individual any information, with respect to any individual, which the Employer deems to be necessary for such purposes. Any individual claiming benefits under this Plan shall furnish to the Employer such information as may be necessary to implement these provisions.

FACILITY OF PAYMENT: Whenever payments which should have been made under this Plan in accordance with these provisions have been made under any other Plans, the Employer shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of these provisions, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the Employer shall be fully discharged from liability under this Plan.

RIGHT OF RECOVERY: Whenever payments have been made by the Employer with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of these provisions, the Employer shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Employer shall determine: any individual to or for or with respect to whom such payments were made, any insurance companies, any other organizations.

SECTION 7 -- SUBROGATION/RIGHT OF REIMBURSEMENT

If a Covered Person files a claim under this Plan for dental expenses incurred as a result of an Injury or sickness due to the act of a third party, the Plan Administrator shall have the right to enforce either the Subrogation or Right of Reimbursement provision below.

The Covered Person* must execute any subrogation/right of reimbursement agreement required by the Plan Administrator prior to receipt of any benefits payable under this Plan. Neither the Subrogation nor Right of Reimbursement provisions and/or agreement may be modified by the Covered Person* unless specifically authorized in writing by the Plan Administrator.

The Covered Person* must furnish the Plan Administrator any and all information that the Plan Administrator may reasonably require to protect the Plan's right of subrogation and/or reimbursement, and shall do nothing to prejudice that right.

Subrogation

- The Covered Person* shall fully cooperate with the Plan Administrator in the pursuit of any and all valid claims the Participant or Dependent may have against the third party and/or his insurer arising out of such act;
- The Plan Administrator will be subrogated to any legal claim the Participant or Dependent may have, and is entitled to assert a lien against the third party;
- Notice of a lien is sufficient to establish the Plan's lien against the third party;
- Any recovery by the Plan Administrator will be limited to the amount of any payments made under the Plan for dental expenses resulting from the negligent or intentional act and the cost of prosecuting the claim including attorney's fees and collection fees.

For purposes of this provision, subrogation means the Plan Administrator has the right to act in place of the Covered Person to make a lawful claim or demand against the third party.

CONFLICTING STATUTES: Although the Plan Administrator may choose to enforce either the Subrogation or Right of Reimbursement provision, if the Subrogation provision conflicts with the laws of the State or the governing jurisdiction, then the Subrogation provision shall not be enforced, and the Right of Reimbursement provision will apply.

Right of Reimbursement

- The Covered Person* shall reimburse this Plan from any money received from the Participant's insurer, a third party, or the third party's insurer;
- Reimbursement will be up to the amount of benefits paid by this Plan;
- A pro rata portion of reasonable attorney's fees and court costs incurred by the Covered Person* in obtaining the third party payment may be deducted from the reimbursement.
- The Plan shall not be responsible for any fees or expenses incurred in connection with the recovery unless it shall have agreed in writing to pay those expenses or fees.

The reimbursement agreement will be binding upon the Covered Person* whether the payment received from the third party or its insurer results from:

- a legal judgment, or
- an arbitration award, or
- a compromise settlement, or
- any other arrangement.

It is not necessary that the dental expenses be itemized in the third party payment or that the third party and/or its insurer admit liability.

Also, the Employer is under no obligation to recover such reimbursement on behalf of the Covered Person*.

*or legal representative/guardian of a minor or incompetent

SECTION 8 -- MEDICARE

The term "Medicare" means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for Medicare Part A at no cost. Ineligible individuals age 65 and over may purchase Medicare Part A by making application and paying the full cost. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage.

Federal legislation requires that ACTIVE Participants, age 65 and over, be given the option to elect the Employer's Plan primary or Medicare. If the affected Participant elects the benefits of this Plan as primary, the regular benefits of the Plan will apply. If a Participant elects Medicare, no benefits will be available under this Plan.

Federal legislation also requires that the spouse, age 65 and over of any active Participant be given the option to elect the Employer's Plan primary or Medicare. If the affected spouse elects the benefits of this Plan as primary, the regular benefits of the Plan will apply. If the spouse elects Medicare, no benefits will be available under this Plan.

The Plan is the primary payor and Medicare is the secondary payor for services that would have been covered by Medicare in the case of:

a Participant or Dependent spouse of a Participant covered under this Plan because of current employment who is entitled to Medicare benefits because of age;

a Participant or Dependent, covered under this Plan as a result of current employment, who is entitled to Medicare benefits because of total disability;

a Participant or Dependent who is entitled to Medicare because of end stage renal disease until the end of the Medicare secondary coordination period.

When Medicare is the primary payor, and a Participant or Dependent entitled to Medicare incurs:

1. hospital, surgical or other charges covered under Medicare, and
2. charges not covered under Medicare,

this Plan's benefits will cover charges incurred to the extent that they are not covered under Medicare. The C.O.B. provision (Section 6) will apply.

Any of the above individuals must apply for Medicare at the earliest opportunity possible. Individuals not meeting the Medicare entitlement requirements must purchase Part A paying full cost. Additionally, all of the above individuals must purchase Medicare Part B paying the full cost. All such individuals will be considered to be covered under both Medicare Parts A & B whether or not actually covered thereunder.

SECTION 9 -- GENERAL PROVISIONS

ADMINISTRATION. Unless otherwise specified in Section 1, the Employer shall be the Plan Administrator of this Plan. The Plan Administrator shall be in charge of and responsible for the operation and administration of the Plan.

The Plan Administrator is hereby designated the named fiduciary with respect to the administration of the Plan and the Trustee, if any, is designated as the named fiduciary with respect to the investment and management of the assets of the Plan. The Plan Administrator shall have the right from time to time to delegate to such persons or entities such Plan administration duties and responsibilities as the Plan Administrator deems appropriate. The Plan Administrator shall maintain such records as shall be necessary for the administration of the Plan. The Plan Administrator shall file all reports and documents which are required by law to be filed by the Plan Administrator. The Plan Administrator shall adopt and implement such procedures, including, but not limited to, utilization review and case management procedures, as are deemed necessary in the sole discretion of the Plan Administrator to administer the Plan.

The Plan Administrator may appoint a Claims Administrator to receive and initially review and process claims for Plan benefits. Any appeals of denied claims for Plan benefits shall be directed to the Plan Administrator for determination. The Plan Administrator shall have the discretionary authority to determine eligibility for Plan benefits and to construe the terms of the Plan, including the making of factual determinations.

The Plan Administrator shall be responsible for forwarding Participants' applications to the Claims Administrator. The Plan Administrator shall also be responsible for notifying the Claims Administrator in writing of any changes with respect to any Covered Persons entitled to coverage, or any other facts necessary for determining Plan coverages and for processing claims for Plan benefits.

This Plan is funded by contributions from the Employer and any required contributions from Covered Persons. The Employer reserves the right to change the contribution rates for Covered Persons at any time and from time to time.

ASSIGNMENT. Benefits provided for by this Plan Document shall not be assignable, however, subject to written direction of the Covered Person*, all or a portion of the benefits, if any, provided for by this Plan for covered dental services may be paid directly to the provider of such service, but it is not required that the service be rendered by a particular provider.

PROOF OF CLAIMS. The payment of any benefit set forth in this Plan Document is subject to the provision that the Covered Person furnish such proof and releases as the Employer or Plan Administrator may reasonably require before approving the payment of any such benefit.

Proof of claim must be given to the Employer or Claims Administrator not later than 15 months after the covered expense is incurred by the Covered Person. Proof of claim consists of completing and filing a claim form with the Claims Administrator. Failure to provide proof of claim within the time specified will not invalidate or reduce any claim if it was not reasonably possible to furnish such proof within the time specified.

PHYSICAL EXAMS. The Plan Administrator, or its Designee shall have the right and opportunity to have a Physician designated by it examine the Covered Person whose injury or sickness is the basis of claim when and so often as it may reasonably require during the pendency of claim hereunder.

CLAIMS REVIEW PROCEDURES. If an applicant's initial claim for Plan benefits is denied in whole or in part, such applicant may request a review of the denied claim by the Claims Administrator. The request for review of the denied claim must be in writing and received by the Claims Administrator within 60 days after the claim was denied. The request for review shall contain the reasons for the request and any additional information or documentation to support the claim for benefits. The Claims Administrator shall consider the request for review and notify the applicant of its decision within 60 days of its receipt of the request. The Claims Administrator's decision shall be in writing and shall set forth:

- the specific reason or reasons for the denial;
- specific reference to pertinent Plan provisions on which denial is based;
- a description of any additional material or information necessary for the claimant to perfect the claim; and
- an explanation of the Plan's claim appeal procedure.

If the decision of the Claims Administrator is to deny the applicant's claim, the applicant may appeal that denial to the Plan Administrator. The appeal must be in writing and received by the Plan Administrator within 60 days after the applicant received the decision of the Claims Administrator. In the event of an appeal, the applicant or the applicant's authorized representative may review pertinent Plan documents relating to the claim denial and may submit issues and comments in writing.

A decision on the appeal will be made within 60 days after receipt of the appeal. The decision will be in writing and will include specific reasons for the decision and specific references to the pertinent Plan provisions on which the decision is based.

FACILITY OF PAYMENT. If any Covered Person is, in the opinion of the Plan Administrator, legally incapable of giving a valid receipt for any payment due him and no guardian has been appointed, the Plan Administrator may, at its option, make such payment to the individual or individuals as have, in the Plan Administrator's opinion, assumed the care and principal support of such Covered Person. If the Covered Person should die before all amounts due and payable to him have been paid, the Plan Administrator may, at its option, make such payment to the executor or administrator of his estate or to his surviving wife, husband, mother, father, child or children, or to any other individual or individuals who are equitably entitled thereto.

Any payment made by the Plan Administrator in accordance with these provisions shall fully discharge the Plan to the extent of such payment.

CHANGE OR DISCONTINUANCE OF BENEFITS. The Employer may at any time change or discontinue the benefits provided in this Plan Document, but no change or discontinuance may affect in any way the amount or the terms of any benefits payable under this Plan Document prior to the date of such change or discontinuance. Any change or discontinuance of the benefits provided in this Plan Document shall be evidenced by a written instrument signed by the Employer.

NONDISCRIMINATION. In the administration of this Plan, the Plan Administrator will act so as not to discriminate unfairly between individuals in similar situations at the time of the action. The Claims Administrator will be entitled to rely on any such action, without being obliged to inquire into the circumstances.

STATEMENTS. No person has the authority to make any verbal statements of any kind at any time which are legally binding upon the Employer, Plan Administrator or alter this Plan Document. No written statement made by a Covered Person shall be used by the Claims Administrator in a contest unless a copy of the instrument containing the statement is or has been furnished to the Covered Person, or the person making the claim.

No statement made by the Employer or Plan Administrator or Covered Person shall void any coverage or reduce any benefits or be used in defense of a claim unless it is in writing.

DISCONTINUANCE OF PLAN. The Plan Administrator may discontinue this Plan with respect to any or all coverage of all Covered Persons, by giving to the Claims Administrator written notice stating when, after the date of such notice, such discontinuance shall become effective; but no such discontinuance shall become effective with respect to any coverage of the Covered Persons of an Employer during any period for which a contribution has been paid to the Claims Administrator with respect to such coverage.

The Claims Administrator reserves the right to discontinue its servicing of this Plan, at any time after the end of the grace period allowed for payment of a service fee which has not been paid, by giving the Employer or Plan Administrator written notice of the discontinuance date. This right is subject to the terms of any applicable law or regulation.

The Claims Administrator may also discontinue its servicing of this Plan in its entirety, at any time, by giving the Plan Administrator advance written notice of the discontinuance date, but the date shall not be earlier than 31 days after the date of the notice unless mutually satisfactory to the Plan Administrator and the Claims Administrator.

If this Plan discontinues as to any coverage of the Covered Persons of an Employer, the Employer or Plan Administrator will be jointly and severally liable to the Claims Administrator for all unpaid service fees for the period in which the Claims Administrator performed services for this Plan.

EFFECT OF PRIOR COVERAGE. Coverage for any Covered Person under this Plan Document replaces any prior coverage in effect for that Covered Person provided by the Employer under any immediately Prior Plan document or policy.

Benefits paid to Covered Persons under such immediately Prior Plan document or policy which were charged against such Prior Plan's maximum lifetime limits (if any) and which accumulate or apply in more than one calendar, plan or fiscal year, shall be carried over and charged against any such maximum lifetime limits under this Plan.

DEDUCTIBLE REQUIREMENT. If the Prior Plan coverage deductible requirement had been fully satisfied during the Calendar Year in which this Plan took effect, this Plan's deductible requirement will be considered satisfied for the balance of that year. Charges which were incurred under the Prior Plan coverage, and which did not qualify for benefits under the Prior Plan coverage solely because of its deductible requirements, will count toward satisfying this Plan's deductible requirement if they meet the following conditions:

1. the charges would qualify as covered dental expenses under this Plan, and

2. this Plan's deductible requirement is satisfied within the prescribed period.

DATA REQUIRED. The Employer or Plan Administrator must furnish the Claims Administrator all information the Claims Administrator reasonably requires as to matters pertaining to this Plan. All material which may have a bearing on coverage or contributions will be open for inspection by the Claims Administrator at all reasonable times during the continuance of this Plan and until the final determination of all rights and obligations under this Plan.

CLERICAL ERROR. Any clerical error (by the Employer, Plan Administrator, or the Claims Administrator) in keeping pertinent records, or a delay in making any entry, will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

MISSTATEMENTS. If any relevant fact as to an individual to whom the coverage relates is found to have been misstated, an equitable adjustment of contributions will be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is in force under this Plan and its amount.

CONFORMITY WITH THE LAW. If any provision of the Plan Document or Employer's Plan is contrary to any law to which it is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

APPLICABLE LAW. The Plan shall be construed and administered in accordance with the laws of the State of the Employer's principal place of business.

SEVERABILITY. In the event that any provision of the Plan shall be held to be illegal or invalid for any reason by a court of competent jurisdiction, such illegality or invalidity shall not affect the remaining provisions of the Plan and the Plan shall be construed and enforced as if such illegal or invalid provision had never been contained in the Plan.

LIABILITY OF DIRECTORS, OFFICERS, AND EMPLOYEES. To the extent permitted by law, no director, officer, or employee of the Employer shall incur any personal liability of any nature for any act done or omitted to be done in good faith in connection with his duties relative to the Plan, except in cases of dishonesty, gross negligence or willful misconduct. Such directors, officers, and employees shall be indemnified and held harmless by the Employer from and against any liability, including reasonable attorneys' fees, to which any of them may be subjected by reason of any such good faith act or conduct in their director, officer, or employee capacity. Any indemnification payments made by reason of this provision shall not be made from the assets of the Plan nor any Trust established in conjunction with the Plan.

PROTECTION AGAINST CREDITORS. To the extent permitted by law and except as otherwise provided in this Section, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, assignment, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void.

NO EMPLOYMENT CONTRACT. Nothing in the Plan shall confer any rights of continued employment to any employee of the Employer or in any way alter an employee's status as a terminable, at will employee of the Employer. Furthermore, the Plan does not constitute a contract of employment.

NO VESTING. The benefits provided under this Plan to Covered Persons are neither guaranteed nor vested benefits.

RECOVERY OF BENEFIT OVERPAYMENT If any Plan benefit paid to or on behalf of a Covered Person should not have been paid or should have been paid in a lesser amount, and the Covered Person* failed to repay the amount promptly, the overpayment may be recovered by the Employer from any monies then payable, or which may become payable, in the form of salary or benefits payable under any of the Employer's sponsored benefit plans or programs including this Plan. The Employer also reserves the right to recover any such overpayments by appropriate legal action.

HEADINGS. The headings of the Plan are for reference only and shall not determine the interpretation or construction of this Plan.

MULTIPLE COUNTERPARTS. This Plan Document may be executed in multiple counterparts, each of the same force and effect.

* or legal representative of a minor or incompetent

SECTION 10 -- HEALTH MAINTENANCE ORGANIZATION

Transfers from HEALTH MAINTENANCE ORGANIZATIONS. Eligibility for Former Health Maintenance Organization (H.M.O.) Members.

If the Employer contracts with a Health Maintenance Organization and the Employer provides a H.M.O. option as an alternative to this Plan, each employee, who is a member of that H.M.O., will have the opportunity to transfer coverage from that H.M.O. to this Plan during the open enrollment period. Coverage under this Plan will become effective on the date agreed upon by the Employer.

The Employer will provide the details of any HMO option.

SECTION 11 -- SCHEDULE OF BENEFITS

DENTAL BENEFITS	MAXIMUM
BENEFIT - **Dental**	$3,000 per Calendar Year
BENEFIT - **Orthodontia**	$1,500 lifetime
DEDUCTIBLE (waived for Preventive Services)	$50 per Calendar Year, per individual (maximum of $150 per family per Calendar Year)
COPAYMENT PERCENTAGE FOR:	
• Preventive Services	100%
• Basic Service	80%
• Major Services	80%
• Orthodontia	50%

SECTION 12 -- DENTAL BENEFITS

BENEFITS PAYABLE. If a Covered Person receives any necessary Dental services or treatment specified in this Section, the Plan, subject to all the provisions of this Plan Document will pay:

100% of Reasonable and Customary expenses for covered **preventive** services.

After the deductible, 80% of Reasonable and Customary expenses for covered **basic and major** services and 50% of Reasonable and Customary expenses for covered **orthodontia** services.

MAXIMUM BENEFIT. For each Covered Person, the maximum amount payable is the Maximum Benefit stated in the Schedule of Benefits.

DENTAL DEDUCTIBLE AMOUNT. The dental deductible amount for each Calendar Year with respect to each Covered Person is the deductible amount in the Schedule of Benefits.

The dental deductible does not apply to **Preventive** services.

If in any Calendar Year covered Family Members shall cumulatively incurred sufficient Covered Expenses to satisfy the deductible specified, the deductible shall be deemed to be satisfied for all covered Family Members in that Calendar Year.

Any part of the deductible satisfied by charges incurred on or after October 1 will go toward the satisfaction of the deductible in the subsequent Calendar Year.

EXTENDED BENEFITS. Dentures or bridges - If a final impression for a denture has been taken, or tooth for a bridge has been prepared, before coverage ceased, then charges for the construction and/or insertion of such denture or bridge will be considered as eligible expenses only to the extent that such construction or insertion procedures are performed within 3 calendar months after termination of coverage.

Dental procedures, other than dentures or bridges, will be considered as eligible expenses if such procedures relate to a particular multiple-appointment dental procedure which had commenced before coverage ceased, but only to the extent that such procedures are performed within 3 calendar months after termination of coverage.

ALTERNATE PROCEDURES. If two (2) or more alternate procedures, services, or courses of treatment may satisfactorily correct a dental condition, the least expensive procedure will be considered for payment. Such determination will be made by the Claims Administrator based upon professionally endorsed standards of dental care.

PREDETERMINATION OF DENTAL CARE COSTS. If the expenses to be incurred for the performance of a Dental Service or series of Dental Services can reasonably be expected to be $200 or more, those expenses may be included as Covered Dental Expenses, provided the Claim Administrator agrees, through Pretreatment Review prior to the performance of the service or services, to accept those expenses as Covered Dental Expenses. If the Claims Administrator does not so agree through Pretreatment Review, or if a description of the procedures to be performed and an estimate of the Dentist's charges are not submitted in advance, the amount of expenses included as Covered Dental Expenses will be determined by the Claim Administrator taking into account alternate procedures, services, or courses of treatment based upon professionally endorsed standards of dental care.

The Participant is responsible for the total dentist's bill irrespective of the amount payable by the Plan.

COVERED DENTAL EXPENSES include Reasonable and Customary necessary expenses incurred for the services and supplies listed below:

Covered Preventive Services

Periodic oral examinations, but not more than twice during any twelve (12) consecutive months.

Prophylaxis, including cleaning, routine scaling and polishing, but not more than four (4) times per Calendar Year.

Topical fluoride application for Dependents age 19, not more than once during any twelve (12) consecutive months.

Palliative emergency treatment and emergency oral examinations.

Topical application of sealant on a posterior tooth for a person less than 14 years old, not more than one treatment per tooth in any thirty-six (36) consecutive months.

Space maintainers, fixed unilateral, excluding orthodontics.

Dental X-rays as follows:

- full mouth X-rays but not more than once during any thirty-six (36) consecutive months;
- bitewing X-rays, but not more than two (2) set(s) in any twelve (12) consecutive months;
- other dental X-rays as deemed necessary.

Infection control supplies.

Covered Basic Services

Fillings (amalgam, composite, plastic and acrylic).

Extractions.

Endodontics (root canal therapy). Any X-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate covered expense.

Repair of removable dentures.

Denture adjustments and relining and/or rebasing.

Recementing of crowns, inlays and/or bridges.

Biopsies of oral tissue.

Pulp vitality tests, but not more than once during any twelve (12) consecutive months.

Home visits by a Physician when Medically Necessary in order to render a covered Dental Service.

Oral surgery.

Apicoectomy.

Hemisection.

General anesthesia administered in connection with a covered dental service only if administered by an individual licensed to administer general anesthesia.

Injection of antibiotic drugs.

Periodontics:

Occlusal equilibration, when no restoration is involved.

Gingivectomy and gingivoplasty.

Gingival curettage.

Scaling and root planing.

Osseous surgery (osteoplasty and ostectomy), including flap entry and closure.

Surgical periodontic examination.

Mucogingivoplastic surgery.

Management of acute periodontal infection and oral lesions.

Covered Major Services

Inlays (not part of bridge).

Onlays (not part of bridge).

Crowns (not part of bridge).

Inlays, onlays, gold fillings, crowns, either restorative or as part of a bridge, including precision attachments for dentures.

Fixed bridge repairs.

Initial dentures, full and partial, and bridges, fixed and removable as follows:

1. Dentures to replace one or more natural teeth extracted while covered under these benefits.

2. Bridgework to replace one or more natural teeth extracted while covered under these benefits (including inlays and crowns to form abutments).

Replacement of or addition of teeth to an existing removable denture (full or partial) or fixed bridgework as follows:

1. replacement or addition of teeth is made necessary by the extraction of natural teeth which occurred while covered under this Plan;

2. replacement is necessary when an immediate temporary denture was inserted shortly following extraction of teeth and cannot be economically modified to the final shape required;

3. the existing denture or bridgework was installed at least five years prior to its replacement and the existing denture or bridgework cannot be made serviceable.

Covered Orthodontia Services (available only to dependent children who are age 18 or less as of the date treatment commences)

Installations of orthodontic appliances and all orthodontic treatments concerned with the reduction or elimination of an existing malocclusion and conditions resulting from that malocclusion through correction of abnormally positioned teeth.

Diagnostic services, including examination, study models, radiographs and all other diagnostic aids used to determine orthodontic needs only once in any five (5) year period, commencing with the date of the initial visit.

Active orthodontic treatment for thirty-six (36) consecutive months or less. Retention treatment for eighteen (18) consecutive months or less.

If active or retention orthodontia treatment began prior to the date of coverage, the maximum number of months for which benefits will be provided will be reduced by the number of months during which treatment was rendered prior to the date of coverage. Covered expenses will be the monthly fee which had been determined by the physician at the time the charges were incurred.

LIMITATIONS APPLICABLE TO DENTAL BENEFITS. Benefits are not payable for:

1. Replacement of defective or lost crown inserted while covered until 5 years have elapsed from the date of insertion.

2. Temporary crowns or gold foil restorations.

3. Appliance replacement performed less than 5 years after a placement or replacement which was performed while covered, except as specified.

4. Replacement at any time of dentures or bridges which can be made serviceable.

5. Denture adjustments during the first 6 months following denture placement performed by the same or associated Physician who provided or repaired the appliance.

6. Appliances or restorations necessary to increase vertical dimensions and/or restore the occlusion.

7. Dental care which is provided solely for the purpose of improving appearance, when form and function of the teeth are satisfactory and no pathological condition exists.

8. Tooth implants.

9. Personalizing dental service by added restorations to artificial teeth, implant dentures, use of magnets, or similar procedures.

10. Charges incurred for dental services which were ordered or started before coverage began, including but not limited to the installation, manufacture or fitting of dental restorations (fillings, inlays, crowns, bridgework and dentures).

11. Expenses related to services or supplies of the type normally intended for sport or home use.

12. Charges for replacement of bridges or dentures lost, misplaced or stolen.

13. Splinting for periodontal purposes and/or other appliances or restorations whose primary purpose is to stabilize periodontally involved teeth.

14. Treatment of Temporomandibular Joint Dysfunction Syndrome (including all myofacial pain syndromes and other associated disorders).

15. Replacement and/or repair of any appliance used during the course of orthodontia treatment.

16. Orthodontia treatment rendered within 5 years after the completion of a course of orthodontia treatment.

SECTION 13 -- GENERAL EXCLUSIONS

No payment will be made under this Plan in any event for the following:

Any treatment or service not prescribed by a Physician.

Any treatment or service resulting from Sickness or Injury which is covered by a Workers' Compensation Act or other similar legislation; or due to Injury or Sickness incurred as the result of, or in the course of, any employment for wage or profit.

Any treatment or service resulting from war or any act of war, declared or undeclared, or participation in insurrection or riot or participation in commission of an assault or felony.

Any expenses where there is no legal obligation or financial liability to pay, or where charges would not be made if there were no coverage under this Plan (except where required by law).

Education or training.

Any treatment or service rendered by a member of the immediate family (employee, spouse, child, brother, sister, or parent of the Covered Person or his spouse).

Any loss caused by intentionally self-inflicted injuries or suicide, while sane or insane.

Any treatment or service which is covered by no-fault (automobile) state provisions or other similar legislation.

Services or supplies which are not necessary.

Charges for failure to keep a scheduled visit or charges for completion of a claim form.

Personal hygiene, comfort or convenience items.

Charges which exceed Reasonable and Customary.

Services or supplies received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustees, or similar person or group.

Any treatment or service which is compensated for or furnished by the local, state or federal government (except where required by law).

Drugs, medical supplies, medical devices, medical equipment, medical or surgical procedures, treatments or services which are Experimental and/or Investigational or do not meet accepted standards of medical practice. A drug, device, treatment, or procedure is considered to be Experimental and/or Investigational:

1. If the device, drug, treatment or procedure has not received the approval or endorsement of the American Medical Association (AMA), U.S. Food and Drug Administration (FDA) or the National Institute of Health (NIH) at the time the device, drug or procedure was furnished; or

2. If reliable evidence demonstrates that the device, drug, treatment or procedure is the subject of ongoing Phase I, II or III Clinical Trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment or diagnosis; or

3. If reliable evidence demonstrates that a consensus of opinion among medical experts regarding the device, drug, treatment or procedure is that further studies or Clinical Trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

"Reliable evidence" means only published reports and articles in authoritative medical and scientific literature, the written protocol(s) used by the treating facility, the protocol(s) of another facility studying substantially the same device, drug, treatment or procedure, or the written informed consent used by the treating facility or another facility studying substantially the same device, drug, treatment or procedure.