SUMMARY PLAN DESCRIPTION

DENTAL PLAN
CITY OF SAN RAFAEL
Concordia FLEX

ADMINISTRATIVE INFORMATION

Plan Name:	City of San Rafael
Informal Plan Name:	Concordia **FLEX**
Employer/Plan Sponsor:	City of San Rafael
Plan Sponsor Tax Identification No.:	94-6000424
Plan Number:	855326000, 855326001, 855326002, 855326003, 855326004, 855326005, 855326006, 855326007, 855326008, 855326009, 855326099, 855326110
Type of Plan:	Group Dental
Type of Administration:	Third Party Administration
Plan Administrator:	Ken Nordoff, City Manager City of San Rafael 1400 Fifth Avenue Suite 10 San Rafael, CA 94915-1560 Telephone numbers: (415) 458-5020
Claims Administrator:	United Concordia Companies, Inc. 4401 Deer Path Road Harrisburg, PA 17110 Telephone number: (800) 332-0366
Agent for Service of Legal Process:	N/A
Funding Medium:	The Plan is funded by employer and employee contributions. The Claims Administrator is not liable for the payment of Plan Benefits.
Trustee(s):	N/A
Plan Year:	January 1 to December 31

INTRODUCTION

This Summary Plan Description is written in an easy-to-understand way to explain the Group Dental Plan ("the Plan") and provide information on the Plan which you may need in the future. If you have any questions after reading this Summary Plan Description, contact the Plan Administrator or the Claims Administrator at the address and telephone number under the Administrative Information section at the beginning of this document.

The Plan is intended to provide dental benefits for eligible employees and their covered dependents.

WHO IS ELIGIBLE FOR COVERAGE

If you are a full-time employee regularly scheduled to work at least 32 hours per week, you are eligible for coverage under the Plan. Your coverage begins after 90 days of full employment or the date the Claims Administrator received your Plan enrollment from the Plan Administrator.

Your existing dependents are eligible on the date you become eligible for employee coverage and their coverage begins when yours begins. Future dependent`s are eligible on the date you acquire them. Their coverage begins the later of the first day of the month following that date or the date the Claims Administrator receives the new dependent's enrollment.

Your eligible dependents are:

- spouse, unless legally separated or domestic partner
- unmarried children, including stepchildren, adopted children, children placed for adoption if you are legally required to provide support until the adoption is finalized, and foster children, who:
  - qualify as your dependent under Internal Revenue Code Section 152, regardless of whether a divorced custodial parent has released the claim to the child's dependency exemptions under Internal Revenue Code Section 152(e).
  - are under age 19 or who are 19 but less than age 23 and are full-time students at an accredited school, college, or university.

ENROLLMENT

Before the beginning of each Plan Year, the Employer will hold an enrollment period during which you may elect benefits under the Plan for the upcoming Plan Year. The enrollment period will begin and end on dates determined by the Plan Administrator. These dates will be prior to the beginning of the next Plan Year. New employees will be enrolled in the Plan upon becoming eligible to participate.

To enroll in the Plan, you must complete the election forms provided by the Plan Administrator. If you do not complete the proper election forms, you may not participate in the Plan. You must let the Plan Administrator know when new dependents become eligible. You must also inform the Plan Administrator when you no longer have eligible dependents. Your employer will notify the Claims Administrator. Individuals eligible for coverage as employees may not also be enrolled as dependents. If you and your spouse are both eligible for employee coverage under the Plan, only one of you can enroll your eligible dependents.

CHANGE IN BENEFIT ELECTIONS

Generally, your Plan elections must stay in effect for the entire Plan Year. There are certain limited circumstances under which you are permitted to change your annual election. The following events are changes that if consistent with the requested change in your benefit election will permit you to change your benefit election during a Plan Year.

- You get married or divorced
- You have a child or adopt a child
- Your spouse or a child dies
- Your spouse commences or terminates employment
- Your or your spouse's employment status changes from full-time to part-time or from part-time to full-time
- You or your spouse take an unpaid leave of absence
- There is a significant change in the dental coverage that is provided by your spouse's employer

COST

You and your employer pays the monthly premium.

HOW THE DENTAL PLAN WORKS

Choice of Dentist

You may choose any licensed dentist for services to be covered by the Plan. However, you will limit your out-of-pocket cost if you choose a United Concordia participating dentist. Participating dentists accept the Plan's allowance as payment in full for covered benefits. Your out-of-pocket cost will be limited to any applicable coinsurance, deductibles or amounts exceeding the program maximum. Participating dentists will also complete and send claims directly to the Claims Administrator.

If you go to a dentist who is not a United Concordia's participating dentist, you may have to pay the dentist at the time of service. You will also have to pay the difference between the dentist's charge and the amount that the Plan allows, in addition to any coinsurance or deductible. You may have to submit the claim and wait for the Claims Administrator to reimburse you.

To find a participating dentist, visit *Find a Dentist* on the Claims Administrator's website at *www.unitedconcordia.com* or telephone the Claims Administrator's Interactive Voice Response System at the toll-free number under the Administrative Information section of this document.

When you visit the dental office, let your dentist know that you are covered under a United Concordia program. If your dentist has questions about your eligibility or benefits, instruct the office to call the Claims Administrator's Interactive Voice Response System at the number under the Administrative Information section of this document or visit *Dental Inquiry* on the Claims Administrator's website at *www.unitedconcordia.com.*

Claims Submission and Payment

Upon completion of treatment, a claim form needs to be filed with the Claims Administrator. If you visit a United Concordia participating dentist, the dental office will submit claims forms for you and your dependents. The Claims Administrator will pay covered benefits directly to the participating dentist. Both you and the dentist will receive an explanation of benefits.

Most dental offices submit claim forms for patients. However, if you do not receive treatment from a participating dentist, you may have to complete and send a claim form to the Claims Administrator in the event the dental office will not do this for you. Send the claim form or predetermination to the address provided by the Claims Administrator. Be sure to include the patient's name, date of birth, the employee's contract ID number, patient's relationship to employee, the employee's name and address, and the name and policy number of a second insurer if the patient is covered by another dental plan. Your dentist should complete the treatment and provider information or supply an itemized receipt for you to attach to the claim form. The Claims Administrator will send payment to you if covered services are provided by a non-participating dentist and you do not indicate on the claim that you wish payment to be sent to the dentist. You will receive an explanation of benefits.

Should you have any questions concerning your coverage, eligibility or a specific claim, contact the Claims Administrator at the address and telephone number on the Administrative Information page of this document or log onto *My Dental Benefits* at *www.unitedconcordia.com*.

Predetermination of Benefits

A predetermination is a review in advance of treatment by the Claims Administrator to determine eligibility and coverage for planned services in accordance with the Schedule of Benefits and the Plan allowance. Predetermination is not required to receive a benefit for any service under the Plan. However, it is recommended for extensive, more costly treatment. A predetermination gives you and your dentist an estimate of what your coverage is and how much your share of the cost will be for the treatment being considered.

To have services predetermined, you or your dentist should submit a claim form showing the planned procedures but leaving out the dates of services. Be sure to sign the predetermination request. Substantiating material such as radiographs and periodontal charting may be requested by the Claims Administrator to estimate benefits. The Claims Administrator will determine benefits payable, taking into account exclusions and limitations and alternate treatment options based upon accepted standards of dental practice. You and your provider, if participating in United Concordia's network, will receive an explanation of the estimated benefits.

When the services are performed, simply have your dentist call the Claims Administrator's Interactive Voice Response System at the telephone number on the Administrative Information page of this document, or fill in the dates of service for the completed procedures on the predetermination notification and re-submit it to the Claims Administrator for processing. Any predetermination amount estimated by the Claims Administrator is subject to continued eligibility of the patient. The Claims Administrator may also make adjustments at the time of final payment to correct any mathematical errors, apply coordination of benefits, and comply with the member's Plan in effect and remaining program maximum dollars at date of service.

BENEFITS

Schedule of Benefits

Your benefits are shown on the attached Schedule of Benefits. The Schedule of Benefits lists:

- the dental service groupings covered, shown with a "Plan Pays" percentage
- the percentage of the Plan allowance that the Plan will pay
- any waiting periods applicable to the services
- any deductibles you must pay before any benefits will be paid by the Plan, and the services excluded from the deductibles
- any maximums for services for a given period of time; for example, annual for most services and lifetime for orthodontics.

If the service grouping is shown on the Schedule of Benefits as not covered or at "Plan Pays -- 0%", no benefits will be paid for the dental procedures in that grouping. Service groupings shown with "Plan Pays" percentages of less than 100% require you to pay a portion of the cost. For example, if the Plan pays 80%, your share is 20% of the Plan allowance.

The general descriptions below explain the service groupings on the Schedule of Benefits. The descriptions are not all-inclusive – they include only the most common dental procedures in a service grouping. Specific dental procedures may be shifted among groupings or may not be covered depending on your Employer's choice of Plan. Check the Schedule of Benefits at the back of this document to see which groupings are covered and have your provider call the Claims Administrator to verify coverage of specific dental procedures. Services covered on the Schedule of Benefits are also subject to the Alternate Treatment Provision following this section and the Schedule of Limitations and Exclusions attached to this document.

- Exams and X-rays for diagnosis – oral evaluations, bitewings, periapical and full-mouth x-rays
- Cleanings, Fluoride Treatments, Sealants for prevention
- Palliative Treatment for relief of pain in emergencies
- Space Maintainers to prevent tooth movement
- Basic Restorative to treat caries (cavities, tooth decay) – amalgam and anterior composite resin fillings, stainless steel crowns, crown build-ups and posts and cores
- Endodontics to treat the dental pulp, pulp chamber and root canal – root canal treatment and retreatment, pulpotomy, pulpal therapy, apicoectomy, and apexification
- Non-surgical Periodontics for non-surgical treatment of diseases of the gums and bones supporting the teeth – periodontal scaling and root planing, periodontal maintenance (prophylaxis)
- Repairs of Crowns, Inlays, Onlays, Bridges, Dentures – repair, recementation, re-lining, re-basing and adjustment
- Simple Extractions – non-surgical extraction of teeth and root removal
- Surgical Periodontics for surgical treatment of the tissues supporting and surrounding the teeth (gums and bone) – gingivectomy, gingivoplasty, gingival curretage, osseous surgery, crown lengthening, bone and tissue replacement grafts
- Complex Oral Surgery for surgical treatment of the hard and soft tissues of the mouth – surgical extractions, impactions, excisions, exposure, and root removal; alveoplasty and vestibuloplasty.
- Anesthesia for elimination of pain during treatment – general or nitrous oxide or IV sedation
- Inlays, Onlays, Crowns when the teeth cannot be restored by fillings
- Prosthetics – fixed bridges, partial and complete dentures
- Orthodontics for treatment of poor alignment and occlusion – diagnostic x-rays, active treatment and retention for eligible dependent children

Alternate Treatment Provision

There are often several ways to treat a dental condition. For example, a filling or a crown can restore a tooth, or a fixed bridge or a partial denture can replace missing teeth. An Alternate Benefit Provision (ABP) will be applied if a dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The Plan will pay for the lesser benefit, professionally acceptable procedure. The ABP does not commit you to the less costly treatment. If you and your dentist choose the more expensive treatment, you are responsible for the additional charges beyond those allowed for the less expensive procedure under the ABP.

Limitations and Exclusions

Services covered by the Plan as indicated on the Schedule of Benefits are subject to frequency or age limitations detailed on the attached Schedules of Limitations and Exclusions. No benefits will be provided for services, supplies or charges detailed under the Exclusions on the attached Schedule of Limitations and Exclusions.

COORDINATION OF BENEFITS

If you or your dependents are covered by any other dental benefits plan and receive a service covered by this Plan and the other, benefits will be coordinated. This means that one plan will be primary and determine its benefits before those of the other plan and without considering the other plan's benefits. The other plan will be secondary and determine its benefits after the other plan. The secondary plan's benefits may be reduced because of the primary plan's payment. Each plan will provide only that portion of its benefit that is required to cover expenses. This prevents duplicate payments and overpayments. Upon determination of primary or secondary liability, this Plan will determine payment.

1. The following words and phrases regarding the Coordination of Benefits ("COB") provision are defined as set forth below:
   - A) **Allowable Amount** is the Plan's allowance for items of expense, when the care is covered at least in part by one or more Plans covering the Member for whom the claim is made.
   - B) **Claim Determination Period** means a benefit year. However, it does not include any part of a year during which a person has no coverage under this Plan.
   - C) **Other Dental Plan** is any form of coverage which is separate from this Plan with which coordination is allowed. **Other Dental Plan** shall be any of the following which provides dental benefits, or services, for the following: Group insurance or group type coverage, whether insured or uninsured. This includes prepayment groups. It also includes coverage other than school accident type coverage (including grammar, high school and college student coverages) for accidents only, including athletic injury, either on a twenty-four (24) hour basis or on a "to and from school basis," or group or group type hospital indemnity benefits of $100 per day or less.
   - D) **Primary Plan** is the plan which determines its benefits first and without considering the other plan's benefits. A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits.
   - E) **Secondary Plan** is the plan which determines its benefits after those of the other plan (Primary Plan). Benefits may be reduced because of the other plan's (Primary Plan) benefits.
   - F) **Plan** means this document including all schedules and all riders thereto, providing dental care benefits to which this COB provision applies and which may be reduced as a result of the benefits of other dental plans.

2. The fair value of services provided by the Claims Administrator shall be considered to be the amount of benefits paid by the Claims Administrator. The Claims Administrator will be fully discharged from liability to the extent of such payment under this provision.

3 In order to determine which plan is primary, the Plan will use the following rules.

A) The other plan does not have a provision similar to this one, then that plan shall be primary.

B) If both plans have COB provisions, the plan covering the Member as a primary insured is determined before those of the plan which covers the person as a Dependent.

C) Dependent Child/Parents Not Separated or Divorced -- The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are:

1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
4) If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

D) Dependent Child/Separated or Divorced Parents -- If two or more plans cover a person as dependent child of divorced or separated parents, benefits for the child are determined in this order:

1) First, the plan of the parent with custody of the child.
2) Then, the plan of the spouse of the parent with the custody of the child; and
3) Finally, the plan of the parent not having custody of the child.
4) If the specific 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. The plan of the other parent shall be the Secondary Plan.
5) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Section C.3. above, titled Dependent Child/Parents Not Separated or Divorced.

E) Active/Inactive Member

1) For actively employed Members and their spouses over the age of 65 who are covered by Medicare, the plan shall be primary.
2) When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, then this rule will be ignored.

F) If none of these rules apply, then the contract which has continuously covered the Member for a longer period of time shall be primary.

G) The plan covering an individual as a COBRA continuee will be secondary to a plan covering that individual as a Member or a Dependent.

4. Right to Receive and Release Needed Information -- Certain facts are needed to apply these COB rules. The Claims Administrator has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Any health information furnished to a third party will be released in accordance with federal law. Each person claiming benefits under This Plan must give any facts needed to pay the claim.

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

6. Right of Recovery -- If the payment made by the Claims Administrator is more than it should have paid under this COB provision, the Claims Administrator may recover the excess from one or more of the following: (1) persons it has paid or for whom it has paid; or (2) insurance companies; or (3) other organization. Members are required to assist the Claims Administrator to implement this section.

SUBROGATION OF BENEFITS

In the event any payment is made under the Plan, the Plan shall be subrogated and shall succeed to the rights of any Participant against any other plan, person or entity for recovery of dental care expenses for which such other plan, person or entity is liable. All amounts so recovered, by settlement, judgment or otherwise, shall be paid to the Plan, for ultimate disposition thereunder, which may include payment to the Employer. Participants shall furnish such information, execute and deliver such assignment documents and other instruments, and take whatever steps are necessary to secure the rights of the Plan and the Employer. Participants shall take no action to prejudice the rights and interests of the Plan or the Employer hereunder.

NON-ALIENATION OF BENEFITS

No right or benefit provided for under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge the same shall be void. However, this Section shall not be construed to prevent a Participant from directing the Plan to pay expenses directly to a provider of services or products if those expenses are otherwise reimbursable to the Participant under Plan. In such event, the Plan shall be relieved of all further responsibility with respect to that particular expense.

TERMINATION OF COVERAGE

Your coverage and/or your dependents' coverage will end on the date provided by the Plan Administrator or the date the Claims Administrator receives the termination notice when the following events occur:

- Your termination of employment with the Plan Administrator.
- Your failure to satisfy the Plan's eligibility requirements.
- Your dependents cease to be dependents as defined by the Plan.
- Your disenrollment from the Plan.
- Your failure to immediately return to work after an approved leave of absence with the Plan Administrator during which you were entitled to receive coverage under the Plan.
- Your fraudulent use of dental services or facilities.
- Your failure to timely pay any required contributions under this Plan.

If your coverage or your dependent's is terminated as described above, coverage for completion of a dental procedure, other than orthodontics, that requires two or more dental office visits on separate days will extend for ninety (90) days after termination. The procedure must be started prior to your termination date. This extension of benefits does not apply if the termination is due to nonpayment of premiums or fraud on your part. In the case of orthodontic treatment, if covered under the Plan, your coverage will extend through the end of the month of termination.

If the Plan is terminated, your coverage will end on the date of the Plan's termination.

COORDINATION WITH OTHER LAWS

Family & Medical Leave Act. A Participant on an Employer approved leave of absence under the Family & Medical Leave Act shall continue to participate in the Plan in accordance with the requirements of such act.

Qualified Medical Child Support Order. To the extent required by ERISA Section 609(a), the Plan shall comply with the terms of any medical child support order determined by the Plan Administrator to constitute a Qualified Medical Child Support Order. A Plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator named in the SPD.

COBRA Continuation Coverage. Notwithstanding the termination provisions of the Plan described above, if the Employer normally employed 20 or more employees on a typical business day during the preceding calendar year, continuation coverage shall be provided under the Plan in accordance with ERISA Section 601 through 608, code Section 4980B, and Title XXII of the Public Health Services Act ("COBRA continuation coverage"). The terms of such COBRA continuation coverage are described below:

a) COBRA continuation coverage shall be offered under the following circumstances ("qualifying events") if participation under the Plan ordinarily would terminate as a result of such circumstances: (1) the Participant's termination of employment (other than by reason of such Participant's gross misconduct) or reduction of work hours to a level that would exclude him and his family from the Plan; (2) the Participant's divorce or legal separation; (3) death of the Participant; (4) the Participant's entitlement of Medicare benefits; (5) a dependent child ceasing to qualify as a "dependent" eligible for coverage under the terms of the Plan; or (6) the commencement by the Employer on or after July 1, 1986 of a Title 11 bankruptcy proceeding. (Item (6) affects only retired Participants, their Spouses and Dependents).

b) COBRA continuation coverage shall be offered only to the Participant and/or his Spouse and his Dependents who were covered under the Plan on the day before the qualifying event occurred and who lose coverage under the Plan on account of the qualifying event ("qualified beneficiaries"). The qualified beneficiary shall be entitled to elect only the type of coverage he was receiving under the Plan at the time of the qualifying event. The right to elect core coverage, i.e., basic hospitalization and major medical coverage, shall be offered separately. Non-core coverage will not be offered separately from core coverage under the Contract.

c) In the case of qualifying event described in (a)(2) or (5) above, the Participant or his family must notify the Employer of the qualifying event within 60 days of the date of the event. In all other cases, the Employer shall be deemed to be notified of the qualifying event. Within 14 days of such notification, the Employer shall provide the Participant and/or his family with a notice of the right to elect COBRA continuation coverage.

d) The Participant, his Spouse, or his Dependent may elect COBRA continuation coverage within 60 days of the later of the date of the qualifying event, or the date to the notice from the Employer to qualified beneficiary. Each qualified beneficiary may make a separate election for COBRA continuation coverage. If an election is made within the 60-day period, the Plan shall permit payment for COBRA continuation coverage during the period preceding such election to be made not less than 45 days after the date of the election. If the election to continue coverage is not made within the above 60-day period, then no further opportunity to continue coverage will be extended to the Participant, his Spouse or his Dependents. COBRA continuation coverage is not conditioned upon evidence of insurability.

e) In the case of (a) (1) above, COBRA continuation coverage may continue for up to 18 months. If, within the first sixty (60) days of continuation coverage, it is determined that the qualified beneficiary was disabled (under Title II or XV of the Social Security Act), continuation coverage may continue an additional 11 months, or a total of 29 months. To qualify for the additional 11 months, the Employer must be notified of the disability within 60 days after the date of determination. Such additional coverage will cease if the disability terminates. Therefore, the Employer must be notified within 30 days of the date of any final determination that the disability no longer exists. In the case of (a)(2) through (5), coverage may continue for up to 36 months. In this case of (a)(6), coverage may continue (1) until the death of the retired Participant or of any qualified beneficiary who, on the day before the qualifying event, was a surviving spouse or dependent child of the Participant, for up to 36 months after the death of the Participant. Notwithstanding the continuation periods specified above, COBRA continuation coverage shall terminate with respect to a qualified beneficiary upon the earlier of:

i The date on which the Employer ceases to provide any group dental plan to any employee;
ii The date upon which coverage under the plan ceases as a result of failure to make timely premium payments as required by (f) below; premium payments shall be considered timely if made within 30 days of the due date; however, coverage shall be terminated retroactively as of the due date if payments are not received within 30 days; non-sufficient fund checks are not payment;
iii The date upon which the qualified beneficiary becomes covered under any other group dental plan (as an employee or otherwise) if such plan does not contain an exclusion or limitation with respect to any preexisting condition of such qualified beneficiary; or
iv The date upon which the qualified beneficiary (other than a qualified beneficiary described in (a) (6) above) becomes entitled to Medicare benefits. In the event of multiple qualifying events, the maximum required continuation period is 36 months.

f) The Plan shall require payment of a premium for any period of COBRA continuation coverage in an amount that shall not exceed 102% of the cost to the Plan for such period of coverage for active Participants with respect to who a qualifying event has not occurred. The cost to the Plan for coverage shall be determined for a period of 12 months selected by the Plan and shall be determined before the beginning of such period. The qualified beneficiary may elect to make any required premium payments in monthly installments. If the COBRA continuation period is extended from 18 months to 29 months due to disability as provided in (e) above, the premium for the additional 11 months of coverage shall be an amount not to exceed 150% of the cost to the Plan for such coverage, rather than 102% of such cost.

PLAN AMENDMENT

The Plan Sponsor reserves the right, at any time, to amend or terminate the Plan or amend or eliminate benefits under the Plan for any reason. All changes will be communicated in writing. If the Plan is discontinued, benefits, if any, will be paid for all charges incurred for covered services prior to the termination date.

ERISA CLAIMS AND APPEAL PROCEDURES

The Plan's ERISA Claims and Appeal Procedures are furnished automatically, without charge, as an attachment to this document and are incorporated by reference into this Summary Plan Description.

ERISA STATEMENT OF RIGHTS

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse and dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a (welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

ERISA CLAIMS AND APPEAL PROCEDURES

United Concordia Companies, Inc. (the "Claims Administrator") will make benefit determinations and resolve claimant appeals in a thorough, appropriate, and timely manner to ensure that claimants are afforded a full and fair review of claims for benefits. Benefit determinations will be made in accordance with the Plan documents and consistently among claimants. The claimant or his/her authorized representative may submit written comments, documents, records and other information relating to claims or appeals. The Claims Administrator will provide a review that takes into account all information submitted whether or not it was considered with its first determination on the claim. Any notifications by the Claims Administrator required under these procedures will be supplied to the claimant or his/her authorized representative.

DEFINITIONS

The following terms when used in this document have the meanings shown below.

"Adverse benefit determination" is a denial, reduction, or termination of or failure to make payment (in whole or in part) based on a determination of eligibility to participate in a plan or the application of any utilization review; or a determination that an item or service otherwise covered is experimental or investigational or not medically (dentally) necessary or appropriate.

"Authorized representative" is a person granted authority by the claimant and the Claims Administrator to act on behalf of a claimant regarding a claim for benefit or an appeal of an adverse benefit determination. An assignment of benefit is not a grant of authority to act on the claimant's behalf in pursuing and appealing a benefit determination.

"Claimant" is a participant and/or beneficiary of an employee welfare benefit plan to whom a benefit may be due.

"Claim for Benefits" is a request for a plan benefit or benefits by a claimant in accordance with the Plan's reasonable procedure for filing benefit claims.

"Claim involving urgent care" is any claim for dental treatment when the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or in the opinion of a dentist with knowledge of the claimant's dental condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Since the Claims Administrator does not require advance approval of emergency care in order to obtain a benefit, there are no claims involving urgent care as defined under the dental plan. The ERISA procedures for claims involving urgent care do not apply.

"Pre-service claim" is any Claim for Benefits under a group health plan when the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care. The Plan does not require approval of planned dental treatment in advance of receiving care. Therefore, there are no pre-service claims as defined under the dental plan, and the ERISA procedures for pre-service claims do not apply. All claims under the dental plan are post-service claims.

"Post-service claim" ("claim") is any Claim for Benefits under a group health plan that is not a pre-service claim.

"Relevant" A document, record, or other information will be considered "**relevant**" to a given claim:

a. if it was relied on in making the benefit determination;
b. if it was submitted, considered, or generated in the course of making the benefit determination (even if the plan did not rely on it);
c. if it demonstrated that, in making the determination, the plan followed its own administrative processes and safeguards for ensuring appropriate decision-making and consistency;
d. or if it is a statement of the plan's policy or guidance concerning the denied benefit, without regard to whether it was relied upon in making the benefit determination.

PROCEDURES FOR POST-SERVICE CLAIMS

Benefit Determinations:

The Claims Administrator will determine benefits and notify claimants of adverse benefit determinations no later than 30 days after receipt of the claim.

The Claims Administrator may extend this 30-day period by 15 days if additional information about the claim is required or the extension is necessary due to matters beyond the control of the Plan. The Claims Administrator will notify the claimant of the extension before the end of the initial 30-day period. The Claims Administrator will explain the circumstances requiring the extension, the additional information required and the date by which the Plan expects to make the benefit determination. The claimant will have 45 days to provide the information requested. The time it takes the claimant to respond to the request for additional information will not be counted toward the time the Claims Administrator is required to make the benefit determination.

When all information is received and the benefit determination is made, the Claims Administrator will send a notice of adverse benefit determination to the claimant. The notice will include:

a. the specific reason for the adverse benefit determination;
b. reference to the specific plan provisions on which the determination is based;
c. description of any additional material or information necessary for the claimant to perfect the claim and why it is necessary;
d. any relevant internal rule, guideline, protocol, criteria, or clinical judgment the plan relied on in making its decision and why it was necessary, or a statement that a copy is available free of charge upon request;
e. a description of the Plan's review procedures and time limits applicable to those procedures;
f. a statement of the claimant's right to bring a civil claim under ERISA.

Appeals:

If the claimant is dissatisfied by the benefit determination, the claimant or his authorized representative may file an appeal with the Claims Administrator within 180 days of receipt of the adverse benefit determination. To file an appeal, telephone the toll-free number listed on your notice of adverse benefit determination.

The Claims Administrator will review the claim and notify the claimant of its decision within 60 days of the request for appeal. Any dentist advisor involved in reviewing the appeal will be different from and not in a subordinate position to the dentist advisor involved in the initial benefit determination.

Notice of the appeal decision will include the following in written or electronic form:

a. the specific reason for the appeal decision;
b. reference to specific plan provisions on which the decision was based;
c. a statement that the claimant is entitled to receive upon request and free of charge, reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts;
d. a statement of the claimant's right to bring a civil action under ERISA;
e. the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

EXCLUSIONS

A charge for the following is not covered.

(1) **Before coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.

(2) **Cosmetic Dentistry.** Charges for or related to Cosmetic Dentistry.

(3) **Crowns**. Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

(4) **Dental Hygienist.** Charges for treatment by other than a Dentist, except expenses for cleaning of teeth performed by a licensed Dental Hygienist, under the supervision of a Dentist.

(5) **Excess charge**. The part of an expense for care and treatment of an injury or illness that is in excess of the Usual and Reasonable Charge.

(6) **Excluded under Medical**. Services that are excluded under Medical Plan Exclusions.

(7) **Government.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(8) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

(9) **Illegal acts**. Charges for services received as a result of injury caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance.

(10) **Implants.** Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.

(11) **Medical services**. Services that, to any extent, are payable under any medical expense benefits of this Plan.

(12) **No charge**. Care and treatment for which there would not have been a charge if no coverage had been in force.

(13) **No listing**. Services which are not included in the list of covered dental services.

(14) **No obligation to pay.** Charges incurred for which this Plan has no legal obligation to pay.

(15) **Not Medically Necessary**. Care and treatment that is not Medically Necessary.

(16) **Occupational.** Care and treatment of an injury or illness that, in either case, is occupational – that is, arises from work for wage or profit, including self-employment.

(17) **Orthognathic surgery.** Surgery to correct a receding or protruding jaw.

(18) **Personalization.** Personalization of dentures.

(19) **Plan design**. Charges excluded or limited by the plan design as stated in this document.

(20) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, domestic partner, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(21) **Replacement.** Replacement of lost or stolen appliances.

(22) **Self-inflicted**. Any loss due to an intentionally self-inflicted injury, while sane or insane.

Note: *This exclusion will not apply if the injury resulted from a medical condition (such as depression).*

(23) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

(24) **TMJ**. All diagnostic and treatment services related to the treatment of jaw joint problems including Temporomandibular Joint (TMJ) Syndrome.

(25) **War**. Any loss that is due to a declared or undeclared act of war.

LIMITATIONS

The limits on Class A Services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

Class A Services: Preventive and Diagnostic Dental Procedures

(1) Routine oral exams. This includes the cleaning and scaling of teeth. Limit of 2 exams per Covered Person every Calendar Year.

(2) Two bitewing x-ray series every Calendar Year.

(3) One full mouth x-ray every 36 months.

(4) Two fluoride treatments for covered dependent children under age 19 every Calendar Year.

(5) Space maintainers for covered dependent children under age 19 to replace primary teeth.

(6) Sealants for covered dependent children under age 16.

(7) Emergency palliative treatment for pain.

Class B Services: Basic Dental Procedures

(1) Dental x-rays not included in Class A.

(2) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than ¼ inch, and all related pathology services.

(3) Periodontics (gum treatments).

(4) Endodontics (root canals)

(5) Extractions. This service includes local anesthesia and routine post-operative care.

(6) Recementing bridges, crowns or inlays.

(7) General anesthetics, upon demonstration of Medical Necessity.

(8) Antibiotic drugs.

(9) Patient consultations.

(10) Restorative services for amalgam, synthetic, plastic or resin restorations (fillings) for treatment of cavities (decay).

(11) Crowns, jackets, cast restorations and the installation of crowns. Limited to one procedure per tooth every 5 Calendar Years.

(12) Repair of crowns, bridgework and removable dentures.

(13) Rebasing or relining of removable dentures. Limited to one rebasing or relining every 36 months.

Class C Services: Major Dental Procedures

(1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

(2) Installing precision attachments for removable dentures.

(3) Installing partial, full or removable dentures to replace one or more natural teeth that were extracted while the person was covered for this benefit. This service also includes all adjustments made during a six-month period following the installation.

(4) Addition of clasp or rest to existing removable dentures.

(5) Initial installation of fixed bridgework to replace one or more natural teeth which were extracted while the person was covered for these benefits.

(6) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:

(a) The replacement or addition of teeth is required because of one or more natural teeth being extracted after the person is covered under these benefits.

(b) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.

(c) The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

DRAFT

Schedule of Benefits

Concordia Flex[sm]

	Plan Pays
Class I Services	
• *Exams*	**100%**
• *Bitewing X-Rays*	**100%**
• *Cleanings & Fluoride Treatments*	**100%**
• *Sealants*	**100%**
• *Palliative Treatment (Emergency)*	**100%**
• *Space Maintainers*	**100%**
Class II Services	
• *All Other X-rays*	**80%**
• *Basic Restorative (Fillings, etc.)*	**80%**
• *Endodontics*	**80%**
• *Non-surgical Periodontics*	**80%**
• *Single Crown*	**80%**
• *Repairs of Crowns, Inlays and Onlays*	**80%**
• *Repairs of Bridges*	**80%**
• *Denture Repair*	**80%**
• *Simple Extractions*	**80%**
• *Surgical Periodontics*	**80%**
• *Complex Oral Surgery*	**80%**
• *General Anesthesia*	**80%**
Class III Services	
• *Inlays, Onlays*	**50%**
• *Prosthetics (Bridges, Dentures)*	**50%**
Orthodontics	
• *Diagnostic, Active, Retention Treatment*	**50%**
• *Limited to Dependent children under the age of 19*	

Deductibles & Maximums

- *$25 per Calendar Year Deductible per Member (excluding Class I & Orthodontics) not to exceed $75 per family*
- *$1,500 per Calendar Year Maximum per Member*
- *$1,000 Lifetime Maximum per Member for Orthodontics*

All services on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations.

Participating Dentists accept the Maximum Allowable Charge as payment in full.

United Concordia

Rider to Schedule of Benefits and Schedule of Exclusions and Limitations

Maternity Dental Benefit

This Rider is effective on May 1, 2008 and is attached to and made a part of the Schedules of Benefits and Schedule of Exclusions and Limitations.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS:

The following limitation is substituted for the limitation on prophylaxis in the Schedule of Exclusions and Limitations:

Prophylaxis – two (2) per Calendar Year. One (1) additional for Members while under the care of a medical professional for pregnancy.

SCHEDULE OF BENEFITS:

Plan Payment percentages, waiting periods, annual maximums and deductibles applicable to Cleanings on the Schedule of Benefits shall apply to the additional prophylaxis provided to a Member while under the care of a medical professional for pregnancy.