BENEFIT PLAN

Government of Guam

PPO Dental
Preferred Provider Organization (PPO)
Dental Plan
Booklet

Prepared exclusively for
Employer: Government of Guam

Plan effective date: October 1, 2020
Plan issue date: October 1, 2021
Welcome

Table of Contents

<table>
<thead>
<tr>
<th>Welcome</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Let’s get started!</td>
<td>4</td>
</tr>
<tr>
<td>Who the plan covers</td>
<td>6</td>
</tr>
<tr>
<td>Medical necessity requirements</td>
<td>9</td>
</tr>
<tr>
<td>What are your eligible dental services?</td>
<td>10</td>
</tr>
<tr>
<td>What rules and limits apply to dental care</td>
<td>11</td>
</tr>
<tr>
<td>An advance claim review</td>
<td>13</td>
</tr>
<tr>
<td>What your plan doesn’t cover - some eligible dental service exclusions</td>
<td>14</td>
</tr>
<tr>
<td>Who provides the care</td>
<td>17</td>
</tr>
<tr>
<td>What the plan pays and what you pay</td>
<td>18</td>
</tr>
<tr>
<td>Claim decisions and appeals procedures</td>
<td>19</td>
</tr>
<tr>
<td>Coordination of benefits (COB)</td>
<td>21</td>
</tr>
<tr>
<td>When coverage ends</td>
<td>24</td>
</tr>
<tr>
<td>Special coverage options after your plan coverage ends</td>
<td>27</td>
</tr>
<tr>
<td>General provisions – other things you should know</td>
<td>29</td>
</tr>
<tr>
<td>Glossary</td>
<td>33</td>
</tr>
<tr>
<td>Discount programs</td>
<td>37</td>
</tr>
</tbody>
</table>

Schedule of benefits | Issued with your booklet
Let’s get started!

Some notes on how we use words
- When we say “you” and “your”, we mean both you and any covered dependents.
- When we say “us”, “we”, and “our”, we mean Carrier when we are describing administrative services provided by Carrier as Third Party Administrator.
- Some words appear in **bold** type and we define them in the *Glossary* section.

Sometimes we use technical dental language that is familiar to dental providers.

What your plan does – providing covered benefits
Your plan provides in-network and out-of-network **covered benefits**. These are **eligible dental services** for which your plan has the obligation to pay.

How your plan works – starting and stopping coverage
Your coverage under the plan has a start and an end. You start coverage after the eligibility and enrollment process is completed. To learn more see the *Who the plan covers* section.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons, such as growing up and leaving home. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn’t necessarily mean you lose coverage with us. See the *Special coverage options after your plan coverage ends* section.

How your plan works while you are covered in-network
Your in-network coverage helps you:
- Get and pay for a lot of – but not all – dental care services. These are called **eligible dental services**
- Pay less cost share when you use a **in-network provider**

**Important note:**
See the schedule of benefits for any **deductibles**, **payment percentage**, and maximum age or visit limits that may apply.

**Eligible dental services**
**Eligible dental services** meet these requirements:
- They are listed in the *Eligible dental services* section in the schedule of benefits.
- They are not carved out in the *What your plan doesn’t cover – some eligible dental service exclusions* section. (We refer to this section as the “Exclusions” section.)
- They are not beyond any limits in the schedule of benefits.

**Carrier’s network of dental providers**
Carrier’s network of **dental providers** is there to give you the care you need. You can find **in-network providers** and see important information about them most easily on our online **provider directory**. Just log into your secure member website.

You can choose any **dental provider** who is in the dental network.
Your plan often will pay a bigger share for eligible dental services that you get through in-network providers, so choose in-network providers as soon as you can.

For more information about the provider directory and the role of your dental provider, see the Who provides the care section.

Paying for eligible dental services— the general requirements
There are general requirements for the plan to pay any part of the expense for an eligible dental service. They are:

- The eligible dental service is medically necessary.
- You get the eligible dental services from in-network or out-of-network providers.

You will find details on medical necessity requirements in the Medical necessity section.

Paying for eligible dental services— sharing the expense
Generally your plan and you will share the expense of your eligible dental services when you meet the general requirements for paying.

But sometimes your plan will pay the entire expense; and sometimes you will. For more information see the What the plan pays and what you pay section, and see the schedule of benefits.

How your plan works while you are covered out-of-network
The section above told you how your plan works while you are covered in-network. You also have coverage when you want to get your care from providers who are not part of the Carrier network. It’s called out-of-network coverage.

Your out-of-network coverage:

- Means you can get care from dental providers who are not part of the Carrier network.
- Means you may have to pay for services at the time that they are provided. You may be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of eligible dental services that you paid directly to a dental provider.
- Means you will pay a higher cost share when you use an out-of-network provider.

You will find details on:

- Out-of-network providers and any exclusions in the Who provides the care section. Cost sharing in the What the plan pays and what you pay section, and your schedule of benefits.
- Claim information in the When you disagree - claim decisions and appeals procedures section.

How to contact us for help
We are here to answer your questions. You can contact us by:

Online tools will make it easier for you to make informed decisions about your dental care, view claims, research care and treatment options, and access information.

Your member ID card
Who the plan covers

You will find information in this section about:
- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible
Your Employer decides and tells us who is eligible for dental care coverage.

When you can join the plan
As an employee you can enroll yourself and your dependents:
- At any time
- Once each Plan Year during the annual enrollment period
- At other special times during the year (see the Special times you and your dependents can join the plan section below)

If you do not enroll yourself and your dependents when you first qualify for dental benefits, you may have to wait until the next annual enrollment period to join.

Who can be on your plan (who can be your dependent)
If your plan includes coverage for dependents, you can enroll the following family members on your plan. (They are referred to in this booklet as your “dependents”.)
- Your legal spouse
- Your domestic partner who meets the rules set by the employer and requirements under state law
- Your dependent children – your own or those of your spouse or domestic partner
  - Under age 26 and they include your:
    - Biological children
    - Stepchildren
    - Legally adopted children, including any children placed with you for adoption
    - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)

You may continue coverage for a disabled child past the age limit shown above. See the Continuation of coverage for other reasons in the Special coverage options after your plan coverage ends section for more information.

Adding new dependents
You can add the following new dependents any time during the year:
- A spouse - if you marry, you can put your spouse on your plan.
  - Your Employer must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask your Employer when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date your Employer receives your completed enrollment information and
Within 31 days of the date of your marriage.

- A domestic partner - if you enter a domestic partnership, you can enroll your domestic partner on your dental plan.
  - Your Employer must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by your Employer.
  - Ask your Employer when benefits for your domestic partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date your Employer receives your completed enrollment information.

- A newborn child – Your newborn child is covered on your dental plan for the first 31 days after birth.
  - To keep your newborn covered, your Employer must receive your completed enrollment information within 31 days of birth.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have dental benefits after the first 31 days.

- An adopted child – A child that you, or that you and your spouse or domestic partner adopts is covered on your plan for the first 31 days after the adoption is complete.
  - To keep your adopted child covered, your Employer must receive your completed enrollment information within 31 days after the adoption.
  - If you miss this deadline, your adopted child will not have dental benefits after the first 31 days.

- A stepchild – You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to your Employer within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild’s parent.
  - Ask your Employer when benefits for your stepchild will begin. It will be either on the date of your marriage, the date your Declaration of Domestic Partnership is filed or the first day of the month following the date your Employer receives your completed enrollment information.

Notification of change in status
It is important that you notify your Employer of any changes in your benefit status. This will help your Employer effectively maintain your benefit status. Please notify your Employer as soon as possible of status changes such as:

- Change of address or phone number
- Change in marital status
- Change of covered dependent status
- A covered dependent who enrolls in any other group dental plan

Late entrant rule

Special times you and your dependents can join the plan
You can enroll in these situations:

- When you did not enroll in this plan before because:
  - You were covered by another group dental plan, and now that other coverage has ended.
  - You had COBRA, and now that coverage has ended.

- You have added a dependent because of marriage, birth, adoption or foster care. See the Adding new dependents section for more information.

- When a court orders that you cover a current spouse, domestic partner, or a minor child on your dental plan.
Your Employer or the party they designate must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

Effective date of coverage
Your coverage will be in effect as of the effective date of the plan if you were eligible for dental benefits at that time.
Medical necessity requirements

The starting point for covered benefits under your plan is whether the services and supplies are eligible dental services. See the Eligible dental services and Exclusions sections plus the schedule of benefits.

Your plan pays for its share of the expense for eligible dental services only if the eligible dental service is medically necessary.

This section addresses the medical necessity requirements.

Medically necessary / medical necessity

The medical necessity requirements are in the Glossary section, where we define "medically necessary, medical necessity".
What are your eligible dental services?

The information in this section is the first step to understanding your plan's eligible dental services. If you have questions about this section, see the How to contact us for help section.

Your plan covers many kinds of dental care services and supplies. Your eligible dental services are listed in the schedule of benefits. There you will find the detailed list of eligible dental services. But sometimes those services are not covered at all or are covered only up to a limit.

You can find out about exclusions in the Exclusions and the What rules and limits apply to dental care sections, and about the limitations in the schedule of benefits.

Dental emergency

Eligible dental services include dental services provided for a dental emergency. The care provided must be a covered benefit.

If you have a dental emergency, you should consider calling your dental in-network provider who may be more familiar with your dental needs. However, you can get treatment from any dentist including one that is an out-of-network provider. If you need help in finding a dentist, call Member Services.

If you get treatment from an out-of-network provider for a dental emergency, the plan pays a benefit at the in-network cost-sharing level of coverage.

For follow-up care to treat the dental emergency, you should consider using your in-network dental provider so that you can get the maximum level of benefits. Follow-up care will be paid at the cost-sharing level that applies to the type of provider that gives you the care.
What rules and limits apply to dental care?

Several rules apply to the dental benefits. Following these rules will help you use your plan to your advantage by avoiding expenses that are not covered by your plan.

**Alternate treatment rule**

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results.

If a charge is made for a non-eligible dental service or supply and an eligible dental service that would provide an acceptable result, then your plan will pay a benefit for the eligible dental service or supply.

If a charge is made for an eligible dental service but another eligible dental service that would provide an acceptable result is less expensive, the benefit will be for the least expensive eligible dental service.

The benefit will be based on the in-network provider’s negotiated charge for the eligible dental service or, in the case of an out-of-network provider, on the recognized charge.

You should review the differences in the cost of alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more costly treatment method. You are responsible for any charges in excess of what your plan will cover.

**Reimbursement policies**

**Replacement rule**

Some eligible dental services are subject to your plan’s replacement rule. The replacement rule applies to replacements of, or additions to existing:

- Crowns
- Inlays
- Onlays
- Implants
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

These eligible dental services are covered only when you give us proof that:

- While you were covered by the plan:
  - You had a tooth (or teeth) extracted after the existing denture or bridge was installed.
  - As a result, you need to replace or add teeth to your denture or bridge.
- The present item cannot be made serviceable, and is:
  - A crown installed at least 8 years before its replacement.
  - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), implant, or other prosthetic item installed at least 8 years before its replacement.
• While you were covered by the plan:
  – You had a tooth (or teeth) extracted.
  – Your present denture is an immediate temporary one that replaces that tooth (or teeth).
  – A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

**Tooth missing but not replaced rule**
The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

• The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth that were removed while you were covered by the plan. (The extraction of a third molar tooth does not qualify.)
• The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 8 years.

Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.
An advance claim review

The purpose of an advance claim review is to provide an estimate, in advance, of what we may pay for proposed services. Knowing ahead of time which services are eligible dental services and what your plan may pay helps you and your dentist make informed decisions about the care you are considering. The estimate is not a guarantee of coverage and payment.

In estimating the amount of benefits payable, we will look at alternate procedures, services, or courses of treatment for the dental condition in question in order to meet the expected result.

The estimate is voluntary. It is not necessary for dental emergency services or routine care such as cleaning teeth or check-ups or any other service.

When to get an advance claim review
An estimate is recommended whenever a course of dental treatment is likely to cost more than $350. Here are the steps involved with getting an advance claim review:

1. Ask your dentist to write down a full description of the treatment you need. They must either use an Carrier claim form or an American Dental Association (ADA) approved claim form.
2. Your dentist should send the form to us before treating you.
3. We may request supporting images and other diagnostic records.
4. Once all of the information has been gathered, we will review the proposed treatment plan and provide you and your dentist with a statement outlining the estimated benefits payable.
5. You and your dentist can then decide how to proceed.

What is a course of dental treatment?
A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more dentists to treat a dental condition that was diagnosed by the attending dentist as a result of an oral examination. A course of treatment starts on the date your dentist first renders a service to correct or treat the diagnosed dental condition.
What your plan doesn’t cover – some eligible dental service exclusions

We already told you about the many dental care services and supplies that are eligible for coverage under your plan in the What are your eligible dental services section. In that section we also told you that some dental care services and supplies have exclusions and some are not covered at all (exclusions).

In this section we tell you about the exclusions that apply to your plan.

And just a reminder, you’ll find benefit and coverage limitations in the schedule of benefits.

Exclusions
The following are not eligible dental services under your plan except as described in:

- The Eligible dental services under your plan section of this booklet or
- A rider or amendment issued to you for use with this booklet:

Charges for services or supplies
- Provided by in-network providers in excess of the negotiated charge
- Provided by an out-of-network provider in excess of the recognized charge
- Provided for your personal comfort or convenience, or the convenience of any other person, including a dental provider
- Provided in connection with treatment or care that is not covered under the plan
- Cancelled or missed appointment charges or charges to complete claim forms
- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage, including:
  - Care in charitable institutions
  - Care for conditions related to current or previous military service
  - Care while in the custody of a governmental authority

Charges in excess of any benefit limits
Any charges in excess of the benefit, dollar, visit, or frequency limits stated in the schedule of benefits.

Cosmetic services and plastic surgery (except to the extent coverage is specifically provided in the Eligible Dental Services section of the schedule of benefits)

- Cosmetic services and supplies including:
  - Plastic surgery
  - Reconstructive surgery
  - Cosmetic surgery
  - Personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
  - Augmentation and vestibuloplasty and other services to protect, clean, whiten, bleach, alter the appearance of teeth whether or not for psychological or emotional reasons
  - Facings on molar crowns and pontics will always be considered cosmetic

Court-ordered services and supplies
- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding.
Dental services and supplies

- Acupuncture, acupressure and acupuncture therapy
- Asynchronous dental treatment
- Crown, inlays and onlays, and veneers unless for one of the following:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants
- Dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion
- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth, all of which were lost while you were not covered
- General anesthesia and intravenous sedation, unless specifically covered and done in connection with another eligible dental service
- Instruction for diet, tobacco counseling and oral hygiene
- Mail order and at-home kits for orthodontic treatment
- **Orthodontic treatment** except as covered in the Eligible Dental Services section of the schedule of benefits
- Dental services and supplies made with high noble metals (gold or titanium) except as covered in the Eligible Dental Services section of the schedule of benefits
- Services and supplies provided in connection with treatment or care that is not covered under the plan
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
- Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons
- **Temporomandibular joint dysfunction/disorder**

Dental services and supplies that are covered in whole or in part:

- Under any other part of this plan
- Under any other plan of group benefits provided by the Customer

Examinations

Any dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- Because a court order requires it.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental or investigational

- **Experimental or investigational** drugs, devices, treatments or procedures
Non-medically necessary services
• Services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary (as determined by Carrier) for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.

Other primary payer
• Payment for a portion of the charge that another party is responsible for as the primary payer

Outpatient prescription drugs, and preventive care drugs and supplements
• Prescribed drugs, pre-medication or analgesia

Personal care, comfort or convenience items
• Any service or supply primarily for your convenience and personal comfort or that of a third party

Providers and other health professionals
• Treatment by other than a dentist. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are:
  – Scaling of teeth
  – Cleaning of teeth
  – Topical application of fluoride.
• Charges submitted for services by an unlicensed provider or not within the scope of the provider’s license.

Services paid under your medical plan
• Your plan will not pay for amounts that were paid for the same services under a medical plan covering you. When a dental service is covered under both plans, we will figure the amount that would be payable under this plan if you did not have other coverage, then subtract what was paid by your medical plan. If there is any difference, this plan will pay it. If the amount paid by your medical plan is equal to or more than the benefit under this plan, this plan will not pay anything for the service.

Services provided by a family member
• Services provided by a spouse, civil union partner, domestic partner, parent, child, step-child, brother, sister, in-law or any household member

Work related illness or injuries
• Coverage available to you under workers’ compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
• A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers’ compensation law or similar law.
• If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered “not work related” regardless of cause.
Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are eligible dental services, the foundation for getting covered care is through our network. This section tells you about in-network and out-of-network providers.

In-network providers
We have contracted with dental providers to provide eligible dental services to you. These dental providers make up the network for your plan. For you to receive the network level of benefits you must use in-network providers for eligible dental services.

The exceptions are:
- Dental emergency services – Refer to the What are your eligible dental services section
- In-network providers are not available to provide the service or supply that you need

You may select in-network providers from the directory or by logging on to our website. You can search our online directory for names and locations of dental providers.

You will not have to submit claims for treatment received from in-network providers. Your in-network provider will take care of that for you. And we will directly pay the in-network provider for what the plan owes.

Out-of-network dental providers
You also have access to out-of-network providers. This means you can receive eligible dental services from an out-of-network provider. If you use an out-of-network provider to receive eligible dental services, you are subject to a higher out-of-pocket expense and are responsible for:
- Your out-of-network payment percentage
- Any charges over our recognized charge
- Submitting your own claims
What the plan pays and what you pay

Who pays for your eligible dental services – this plan, both of us, or just you? That depends. This section gives the general rule and explains these key terms:

- Your payment percentage
- Your maximums

We also remind you that sometimes you will be responsible for paying the entire bill – for example, if you get care that is not an eligible dental service.

The general rule

When you get eligible dental services:

- Your plan and you share the expense up to any Plan Year and lifetime maximum. The schedule of benefits lists how much you pay and how much your plan pays. The payment percentage may vary by the type of expense. Your share is called payment percentage.
  
  And then
  
  - You are responsible for any amounts above the maximum.

When we say “expense” in this general rule, we mean the negotiated charge for in-network providers, and recognized charge for out-of-network providers. See the Glossary section for what these terms mean.

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses or costs in excess of the negotiated charge for in-network covered benefits

The maximum is the most your plan will pay for eligible dental services per Plan Year and lifetime incurred by you or your covered dependent. You are responsible for any amounts above the maximum.
Claim decisions and appeals procedures

In the previous section, we explained how you and the plan share responsibility for paying for your eligible dental services.

When a claim comes in, your employer decides how you and the plan will split the expense. We also explain what you can do if you think we got it wrong.

Claims are processed in the order in which they are received.

Claim procedures
You or your dental provider are required to send us a claim in writing. You can request a claim form from us. We will review that claim for payment to the provider or to you as appropriate.

The table below explains the claim procedures as follows:

<table>
<thead>
<tr>
<th>Notice</th>
<th>Requirement</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit a claim</td>
<td>• You should notify and request a claim form from your employer&lt;br&gt;• The claim form will provide instructions on how to complete and where to send the form(s)</td>
<td>• You must send us notice and proof within 90 days&lt;br&gt;• If you are unable to complete a claim form, you may send us:&lt;br&gt;  – A description of services&lt;br&gt;  – Bill of charges&lt;br&gt;  – Any dental documentation you received from your dental provider</td>
</tr>
<tr>
<td>Proof of loss (claim)</td>
<td>• A completed claim form and any additional information required by your employer</td>
<td>• You must send us notice and proof within 90 days</td>
</tr>
<tr>
<td>When you have received a service from an eligible dental provider, you will be charged. The information you receive for that service is your proof of loss.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit payment</td>
<td>• Written proof must be provided for all benefits&lt;br&gt;• If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.</td>
<td>• Benefits will be paid as soon as the necessary proof to support the claim is received</td>
</tr>
</tbody>
</table>

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if it is filed as soon as possible. Unless you are legally incapacitated, late claims will not be covered if
they are filed more than 24 months after the deadline.

**Communicating our claim decisions**

**Adverse benefit determinations**

**The difference between a complaint and an appeal**

**A complaint**
You may not be happy about a dental provider or an operational issue, and you may want to complain. You can call or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

**An appeal**
You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us verbally or in writing.

**Appeals of adverse benefit determinations**

**Timeframes for deciding appeals**

**Exhaustion of appeals process**

**Recordkeeping**

**Fees and expenses**
Coordination of benefits

Some people have dental coverage under more than one plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

Key terms
Here are some key terms we use in this section. These terms will help you understand this COB section.

Allowable expense means:
- A dental care expense that any of your dental plans cover to any degree. If the dental care service is not covered by any of the plans, it is not an allowable expense. For example, cosmetic surgery generally is not an allowable expense under this plan.

In this section we talk about other “plans” which are those plans where you may have other coverage for dental care expenses, such as:
- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile insurance policy
- Medicare or other governmental benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Here’s how COB works
- The primary plan pays first. When this is the primary plan, we will pay your claims first as if the other plan does not exist.
- The secondary plan pays after the primary plan. When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid.
- We will never pay an amount that, when combined with payments from your other coverage, add up to more than 100% of the allowable expenses.

Determining who pays
Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

A plan that does not contain a COB provision is always the primary plan.
<table>
<thead>
<tr>
<th>If you are:</th>
<th>Primary plan</th>
<th>Secondary plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered under the plan as an employee, retired employee or dependent</td>
<td>The plan covering you as an employee or retired employee</td>
<td>The plan covering you as a dependent</td>
</tr>
<tr>
<td></td>
<td>You cannot be covered as an employee and dependent</td>
<td></td>
</tr>
<tr>
<td>COB rules for dependent children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Parents who are married or living together</td>
<td>The “birthday rule” applies</td>
<td>The plan of the parent born later in the year (month and day only)*</td>
</tr>
<tr>
<td>The plan of the parent whose birthday* (month and day only) falls earlier in the Plan Year</td>
<td>*Same birthdays--the plan that has covered a parent longer is primary</td>
<td>*Same birthdays--the plan that has covered a parent longer is primary</td>
</tr>
<tr>
<td>Child of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Parents separated or divorced or not living together</td>
<td>The plan of the parent whom the court said is responsible for dental coverage</td>
<td>The plan of the other parent</td>
</tr>
<tr>
<td>• With court-order</td>
<td>But if that parent has no coverage then the other spouse’s plan</td>
<td>But if that parent has no coverage, then his/her spouse’s plan is primary</td>
</tr>
<tr>
<td>Child of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody</td>
<td>Primary and secondary coverage is based on the birthday rule</td>
<td></td>
</tr>
<tr>
<td>Child of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Parents separated or divorced or not living together and there is no court-order</td>
<td>The order of benefit payments is:</td>
<td></td>
</tr>
<tr>
<td>• Child covered by:</td>
<td>• The plan of the custodial parent pays first</td>
<td></td>
</tr>
<tr>
<td>Individual who is not a parent (i.e. stepparent or grandparent)</td>
<td>• The plan of the spouse of the custodial parent (if any) pays second</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The plan of the noncustodial parents pays next</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The plan of the spouse of the noncustodial parent (if any) pays last</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treat the person the same as a parent when making the order of benefits determination:</td>
<td></td>
</tr>
<tr>
<td>See Child of content above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active or inactive employee</td>
<td>The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee)</td>
<td>A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee)</td>
</tr>
<tr>
<td>COBRA or state continuation</td>
<td>The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage</td>
<td>COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree</td>
</tr>
<tr>
<td>----------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Longer or shorter length of coverage</td>
<td>If none of the above rules determine the order of payment, the plan that has covered the person longer is primary</td>
<td></td>
</tr>
<tr>
<td>Other rules do not apply</td>
<td>If none of the above rules apply, the plans share expenses equally</td>
<td></td>
</tr>
</tbody>
</table>

### How are benefits paid?

<table>
<thead>
<tr>
<th>Primary plan</th>
<th>The primary plan pays your claims as if there is no other dental plan involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary plan</td>
<td>The secondary plan calculates payment as if the primary plan did not exist, and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan. The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense</td>
</tr>
</tbody>
</table>

### Other dental coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly. See the *How to contact us for help* section for details.

### Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other dental plans.

### Right to pay another carrier

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

### Right of recovery

If we pay more than we should have under the COB rules, we may recover the excess from:
- Any person we paid or for whom we paid
- Any other plan that is responsible under these COB rules.
When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends.

When will your coverage end?
Coverage under this plan will end if:

- This plan is discontinued
- You voluntarily stop your coverage
- You are no longer eligible for coverage
- Your employer has notified us that your employment is ended
- You do not make any required contributions
- You become covered under another dental plan offered by your employer
When coverage may continue under the plan

Your coverage under this plan will continue if:

| Your employment ends because of **illness**, injury, sabbatical or other authorized leave as agreed to by your employer and us. | If required contribution payments are made for you, you may be able to continue to coverage under the plan as long as your employer agrees to do so and as described below:
  - Your coverage may continue, until stopped by your employer, but not beyond 30 months from the start of your absence. |
|---|---|
| Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by your employer. | If contribution payments are made for you, you may be able to continue to coverage under the plan as long as your employer agrees to do so and as described below:
  - Your coverage will stop on the date that your employment ends. |
| Your employment ends because:
  - Your job has been eliminated
  - You have been placed on severance, or
  - This plan allows former employees to continue their coverage. | You may be able to continue coverage. See the *Special coverage options after your plan coverage ends* section. |
| Your employment ends because of a paid or unpaid medical leave of absence | If contribution payments are made for you, you may be able to continue to coverage under the plan as long as your employer agrees to do so and as described below:
  - Your coverage may continue until stopped by your employer but not beyond 30 months from the start of the absence. |
| Your employment ends because of a leave of absence that is not a medical leave of absence | If contribution payments are made for you, you may be able to continue to coverage under the plan as long as your employer agrees to do so and as described below:
  - Your coverage may continue until stopped by your employer but not beyond 1 month from the start of the absence. |
| Your employment ends because of a military leave of absence. | If contribution payments are made for you, you may be able to continue to coverage under the plan as long as your employer agrees to do so and as described below:
  - Your coverage may continue until stopped by your employer but not beyond 24 months from the start of the absence. |

It is your employer’s responsibility to let us know when your employment ends. The limits above may be extended only if your employer agrees in writing to extend them.
When will coverage end for any dependents?

Coverage for your dependent will end if:
- Your dependent is no longer eligible for coverage
- You do not make the required contribution toward the cost of dependents’ coverage
- Your coverage ends for any of the reasons listed above

In addition, coverage for your domestic partner or civil union partner will end on the earlier of:
- The date this plan no longer allows coverage for domestic partners or civil unions
- The date the domestic partnership or civil union ends. For domestic partnerships, you should provide your employer a completed and signed Declaration of Termination of Domestic Partnership.

Why coverage could end for you and your dependents?

Your employer may end your coverage for any number of reasons—for some reasons your employer will give you notice before terminating your coverage, for other reasons your employer may terminate your coverage immediately.

Your employer will give you 30 days advance written notice if your employer ends your coverage because you commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the General provisions – other things you should know section for more information on rescissions.

On the date your coverage ends, we will refund to your employer any prepayments for periods after the date your coverage ended.
Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

Continuation of coverage for other reasons

What exceptions are there for dental work when coverage ends?

Your dental coverage may end while you or your covered dependent are in the middle of treatment. The plan does not cover dental services that are given after your coverage terminates. There is an exception. The plan will cover the following services if they are ordered while you were covered by the plan, and installed within 30 days after your coverage ends:

- Inlays
- Onlays
- Crowns
- Removable bridges
- Cast or processed restorations
- Dentures
- Fixed partial dentures (bridges)
- Root canals

Ordered means:

- For a denture: The impressions from which the denture will be made were taken
- For a root canal: The pulp chamber was opened
- For any other item: The teeth which will serve as retainers or supports, or the teeth which are being restored:
  - Must have been fully prepared to receive the item
  - Impressions have been taken from which the item will be prepared

How can you extend coverage for your disabled child beyond the plan age limits?

You have the right to extend dental coverage for your dependent child beyond the plan age limits. If your disabled child:

- Is not able to be self-supporting because of mental or physical disability, and
- Depends mainly (more than 50% of income) on you for support

The right to coverage will continue only as long as a physician certifies that your child still is disabled.

We may ask you to send us proof of the disability within 31 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won’t ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don’t, we can terminate coverage for your dependent child.

Your disabled child’s coverage will end:

- On the date the child is no longer disabled and dependent upon you for support or
- As explained in the When will coverage end for any dependents section
**How can you extend coverage for a child in college on medical leave?**

You have the right to extend coverage for your dependent college student who takes a **medically necessary** leave of absence from school. The right to coverage will be extended until the earlier of:

- One year after the leave of absence begins, or
- The date coverage would otherwise end

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious **illness** or **injury**,  
- Cause the dependent child to lose status as a full-time student under the plan  
- Be certified by the treating **physician** as **medically necessary** due to a serious **illness** or **injury**

We must receive documentation or certification of the **medical necessity** for a leave of absence:

- At least 30 days prior to the absence, if the medical reason for the absence and the absence are foreseeable, or  
- 30 days after the start date of the medical leave of absence from school

The **physician** treating your child will be asked to keep us informed of any changes.
General provisions – other things you should know

Administrative provisions
How you and we will interpret this booklet
We prepared this booklet according to ERISA, and according to other federal and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this booklet when we administer your coverage, so long as we use reasonable discretion.

How we administer this plan
We apply policies and procedures we’ve developed to administer this plan.

Who’s responsible to you
We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your providers. They are not our employees or agents.

Coverage and services
Your coverage can change
Your coverage is defined by the group contract. This document may have amendments too. Under certain circumstances, we or the customer or the law may change your plan. Only Carrier may waive a requirement of your plan. No other person – including the customer or provider – can do this.

If a service cannot be provided to you
Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can’t, we may refund you or your customer any unearned fee.

Financial sanctions exclusions:
If coverage provided under this booklet violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for eligible dental services if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Assets Control (OFAC). You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Legal action
We encourage you to complete the appeal process before you take any legal action against us for any expense or bill. You cannot take any action until 60 days after we receive written submission of claim. See the When you disagree - claim decisions and appeals procedures section.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Physical examinations and evaluations
At our expense, we have the right to have a provider of our choice examine you. This will be done at all reasonable times while a claim for benefits is pending or under review.
Records of expenses
You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:
- Names of dental providers, dentists and others providers who provide services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception
Honest mistakes
You or your customer may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in fee contribution or in your coverage. If we do, we will tell you what the mistake was. We won’t make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception
If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:
- Loss of coverage, starting at some time in the past. If we paid claims for your past coverage, we will want the money back.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

Some other money issues
Assignment of benefits
When you see in-network providers they will usually bill us directly. When you see out-of-network providers, we may choose to pay you or to pay the provider directly. Unless we have agreed to do so in writing and to the extent allowed by law, we will not accept an assignment to an out-of-network provider under this group contract. This may include:
- The benefits due
- The right to receive payments or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this group contract

To request assignment you must complete an assignment form. The assignment form is available from the customer. The completed form must be sent to us for consent.

Recovery of overpayments
If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan’s third-party administrator - Carrier. Under this process, Carrier reduces future payments to providers by the amount of the overpayment they received, and then credit the recovered amount
to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Carrier recovers overpayments for other plans administered by Carrier.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

**Payment of fees**
The first fee payment for this contract is due on or before your effective date of coverage. Your next fee payment will be due the 1st of each month ("fee due date"). Each fee payment is to be paid to us on or before the fee due date.

**Your dental information**
We will protect your dental information. We will use it and share it with others to help us process your providers’ claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just call Member Services at carrier number. When you accept coverage under this plan, you agree to let your providers share your information with us. We will need information about your physical and mental condition and care.

**Effect of benefits under other plans**

**Effect of a Health Maintenance Organization plan (an HMO plan) on coverage**
If you are eligible and have chosen dental coverage under an HMO plan offered by the customer, you will be excluded from dental coverage under this plan on the date of your coverage under the HMO plan.

<table>
<thead>
<tr>
<th>If you and your covered dependents:</th>
<th>Change of coverage:</th>
<th>Coverage takes effect:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live in an HMO plan enrollment area</td>
<td>During an open enrollment period</td>
<td>Group contract anniversary date after the open enrollment period</td>
</tr>
<tr>
<td>Live in an HMO plan enrollment area</td>
<td>Not during an open enrollment period</td>
<td>Only if and when we give our written consent</td>
</tr>
<tr>
<td>Move from an HMO plan enrollment area or the HMO discontinues</td>
<td>Within 31 days</td>
<td>On the date you elect such coverage</td>
</tr>
<tr>
<td>Move from an HMO plan enrollment area or the HMO discontinues</td>
<td>After 31 days</td>
<td>Only if and when we give our written consent</td>
</tr>
</tbody>
</table>

No benefits will be paid for any charges for services rendered or supplies received under an HMO plan.

**Effect of prior coverage - transferred business**
Prior coverage means:
- Any plan of group coverage that has been replaced by coverage under part or all of this plan.
- The plan must have been sponsored by the customer (e.g., transferred business).
- If you are eligible, the replacement can be complete, or in part for your eligible class. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.
If your coverage under any part of this plan replaces any prior coverage any benefits provided under such prior coverage may reduce benefits payable under this plan. See the General coverage provisions section of the schedule of benefits.

Dental coverage under this plan will continue uninterrupted for your dependent college student who takes a medically necessary leave of absence from school. See the Special coverage options after your plan coverage ends – How can you extend dental coverage for a child in college on medical leave? section.
Glossary

Carrier
Insurance Company, an affiliate, or a third party vendor under contract with Carrier.

Calendar year
A period of 12 month beginning on January 1st and ending on December 31st.

Calendar year maximum
This is the most this plan will pay for eligible dental services incurred by you during the calendar year.

Contribution
The amount you or the customer are required to pay to Carrier to continue coverage.

Copayments
The specific dollar amount you have to pay for eligible dental services. Copayments may be changed by Carrier upon 30 days written notice to the customer.

Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits
Eligible dental services that meet the requirements for coverage under the terms of this plan.

Deductible
The amount you pay for eligible dental services per calendar year before your plan starts to pay.

Dental emergency
Any dental condition that:
• Occurs unexpectedly
• Requires immediate diagnosis and treatment in order to stabilize the condition, and
• Is characterized by symptoms such as severe pain and bleeding

Dental emergency services maximum
The most the plan will pay for eligible dental services incurred by any one covered person for any one dental emergency is called the dental emergency services maximum.

Dental emergency services
Services and supplies given by a dental provider to treat a dental emergency.

Dental provider
Any individual legally qualified to provide dental services or supplies.

Dentist
A legally qualified dentist licensed to do the dental work he or she performs.
Directory
The list of in-network providers for your plan. The most up-to-date directory for your plan. When searching for in-network providers, you need to make sure that you are searching for providers that participate in your specific plan. In-network providers may only be considered in-network providers for certain Carrier plans.

Effective date of coverage
The date you and your dependent’s coverage begins under this booklet as noted in our records.

Eligible dental services
The dental care services and supplies listed in the schedule of benefits and not listed or limited in the What rules and limits apply to dental care and Exceptions sections of this plan.

Experimental or investigational
A drug, device, procedure, or treatment that we find is experimental or investigational because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the illness or injury involved.
- The needed approval by the FDA has not been given for marketing.
- A national medical or dental society or regulatory agency has stated in writing that it is experimental or investigational or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility provider state that it is experimental or investigational.
- It is provided or performed in a special setting for research purposes.

Health professional
A person who is licensed, certified or otherwise authorized by law to provide dental care services to the public. For example, providers and dental assistants.

Illness
Poor health resulting from disease of the teeth or gums.

Injury or injuries
Physical damage done to the teeth or gums.

In-network provider
A provider listed in the directory for your plan.

Medicare
As used in this plan, Medicare means the health coverage provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.
Medically necessary/medical necessity
Dental care services that we determine a provider using sensible clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that we determine are:
- In accordance with generally accepted standards of dental practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease
- Not primarily for the convenience of the patient, dentist, or other health care provider
- Not more costly than an alternative service or sequence of services at least as likely to produce the same benefit or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease

Generally accepted standards of dental practice means standards based on credible scientific evidence published in peer-reviewed dental literature and is:
- Generally recognized by the relevant dental community
- Consistent with the standards set forth in policy issues involving clinical judgment

Negotiated charge
This is either:
- The amount in-network providers have agreed to accept
- The amount we agree to pay directly to in-network providers or third party vendor (including any administrative fee in the amount paid)

Orthodontic treatment
This is any:
- Medical service or supply
- Dental service or supply

furnished to prevent or to diagnose or to correct a misalignment:
- Of the teeth
- Of the bite
- Of the jaws or jaw joint relationship

whether or not for the purpose of relieving pain.

The following are not considered orthodontic treatment:
- The installation of a space maintainer
- A surgical procedure to correct malocclusion

Out-of-network provider
A provider who is not a in-network provider and does not appear in the directory for your plan.

Payment Percentage
The specific percentage we have to pay for eligible dental services.

Physician
A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.
Provider
A dentist, or other entity or person licensed, or certified under applicable state and federal law to provide dental care services to you.

Recognized charge
The amount of an out-of-network provider’s charge that is eligible for coverage. You are responsible for all amounts above the recognized charge. The recognized charge may be less than the provider’s full charge.

Your plan’s recognized charge applies to all out-of-network eligible dental services. In all cases, the recognized charge is based on the geographic area where you receive the service or supply.

Except as otherwise specified below, the recognized charge for each service or supply is the lesser of what the provider bills and:

- 80% of the prevailing charge rate

The recognized charge for providers in the dental out-of-network savings program is the lesser of what the provider bills and the agreed upon rate for providers, with whom we have a contract through any third party that is not an affiliate of Carrier.

Your out-of-network cost sharing applies when you get care from dental out-of-network savings program providers except for emergency services.

Special terms used:
 Geographic area
 The geographic area made up of the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

 Prevailing charge rate:
 The 80th percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we have the right to substitute an alternative database that we believe is comparable.

Temporomandibular joint dysfunction/disorder
This is:
- A temporomandibular joint (TMJ) dysfunction/disorder or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves
Discount programs

Discount arrangements
We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called “third party service providers”. These third party service providers may pay us so that they can offer you their services.

Third party service providers are independent contractors. The third party service provider is responsible for the goods or services they deliver. We have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don’t pay the third party service providers for the services they offer. You are responsible for paying for the discounted goods or services.

Wellness and other incentives
We may encourage and incent you to access certain dental services, to use online tools that enhance your coverage and services and to continue participation as an Carrier member. You and your provider can talk about these dental services and decide if they are right for you. We may also encourage and incent you to participate in a wellness or health improvement program. Incentives may include but are not limited to:

- Modification to deductible or payment percentage amounts
- Fee discounts or rebates
- Contributions to a health savings account
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards
- Any combination of the above

The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon a member's health status.
Additional Information Provided by

Government of Guam

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, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an 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.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Assistance with Your Questions
If you have any questions about your Plan, you should contact the Plan Administrator.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law
This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Carrier and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.
Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Carrier gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.