UNITED BENEFIT FUND

DENTAL PROGRAM

Administered By: **United Benefit Fund**
40-26 235th Street
Douglaston, NY 11363
718-513-2477
www.unitedbenefitfund.com

Labial Surface
Central Incisor
Lateral Incisor
Cuspid
Single Rooted
1st Bicuspid (Bi-Rooted)
2nd Bicuspid (Single Rooted)
Buccal (Facial) Surface
Lingual Surface
1st Molar
2nd Molar
3rd Molar
Tri-Rooted
Mesial Surface
Distal Surface
Maxillary Arch (Upper Jaw)
Primary
Permanent
Top Right (TR) Quadrant I
Top Left (TL) Quadrant II
Right
Left
Bottom Right (BR) Quadrant IV
Bottom Left (BL) Quadrant III
Mandibular Arch (Lower Jaw)
3rd Molar
2nd Molar
1st Molar
Bi-Rooted
Occlusal Surface
Lingual Surface
2nd Bicuspid
1st Bicuspid
Single Rooted
Cuspid
Lateral Incisor
Central Incisor
Single Rooted
Incisal Surface

SCHEDULE OF BENEFITS

PLAN EFFECTIVE DATE: .... January 1, 2024

EMPLOYEES ELIGIBLE: .... All Full-Time Eligible Participants

EMPLOYEES NOT ELIGIBLE: .... All Part-Time, Temporary and Retired Employees

DEPENDENTS ELIGIBLE: .... All dependents listed as eligible

Calendar Year maximum: .... $5,000 per Individual or Family

This document is intended to advise you of the Schedule of Benefits, rules and regulations of the Dental Program of the United Benefit Fund ("UBF"). This document supplements the Summary Plan Description ("SPD") previously provided to you. You should retain this document with your copy of the SPD. In the event of any conflict or inconsistency between the SPD and this document regarding the Dental Program, the provisions of this document shall control and take precedence.

Dental Co-Insurance Rates

There is a $10 Co-Payment for all dental visits. $10.00 Per Visit.

WHEN YOUR COVERAGE BEGINS

BECOMING ELIGIBLE

If you are in covered employment on the Plan Effective Date, you will be eligible on that date. Otherwise, your coverage begins the first day of the month following the date of your covered employment.

If you are not actively at work on the day you would normally become eligible, you will be eligible on the day you return to active work.

You and your dependents will be insured:

(a) on the day you become eligible.

WHEN YOUR DEPENDENTS' COVERAGE BEGINS

This term means:

(a) your spouse.

(b) each of your single children. The term "children" also includes any child who is related to you by blood or marriage; and any other child if that child lives in your household in a parent-child relationship and is dependent on you for support.

Each child must be under age twenty-six. If your child is mentally ill, developmentally disabled, mentally retarded or has a physical handicap when coverage would end due to the child's age (all dependent's get COBRA at age 26). Ask your Plan Administrator within thirty-one days of the date your child's coverage ends for details and forms.

If any of your dependents are eligible under this plan as an employee, that person is not eligible for coverage as a dependent. If both you and your spouse (whether married, legally separated or divorced) are covered under this plan as employees, both will be permitted to enroll your spouse and eligible children as dependents.

Your dependents will be covered on the day they become eligible.

DENTAL BENEFITS

WHAT IS COVERED

Benefits are payable for Covered Dental Charges incurred while the person is covered for these benefits.

WHAT ARE COVERED DENTAL CHARGES

Covered Dental Charges are charges incurred for any service or supply included in the Schedule of Dental Procedures. A list of covered procedures is shown at the end of this booklet. Covered Dental Charges do not include services which are excluded pursuant to the Plan Guidelines.

If Covered Dental Charges for any course of treatment are expected to be more than $500 and you wish an estimate of any benefits that would be payable, your dentist may submit a treatment plan for pre authorization.

MAXIMUM DENTAL BENEFIT

The Maximum Dental Benefit that will be paid for a covered person in a calendar year is $5,000 Per Individual and $5,000 Per Family.

DENTAL PLAN EXCLUSIONS

Covered Dental Charges do not include charges for services and supplies made in the absence of insurance. No coverage is provided for loss caused by or resulting from:

(1) Injury arising our or in the course of employment: or which is compensable under any Workers' Compensation **or** Occupational Disease Act or Law;

(2) Declared or undeclared war; or act of war;

(3) Intentionally self-inflicted injury or Sickness;

(4) A Service furnished for:

a. Cosmetic purposes, unless needed as a result of injury.

b. Dental care of a congenital or developmental malformation,

(5) Appliances, restorations or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, or replacing tooth structure lost as a result of abrasion or attrition.

(6) A service not furnished by a Dentist or a licensed dental hygienist under a dentist's supervision;

(7) The replacement of Crowns, Dentures & Bridges if less than 5 years old;

(8) Appliances related to periodontal treatment (Bruxism, Night Guards)

(9) Services provided by a member of a Covered Person's immediate family;

(10) For these items:

a. athletic mouthguards.

b. Oral hygiene instruction, dietary, plaque control and other educational programs.

c. Out of Network Benefits

d. Implants

e. Orthodontics (You are eligible to use the Discount Plan)

IMPORTANT: See "General Information" for other conditions that may affect this coverage.

WHEN IS A CHARGE INCURRED

A charge is incurred on:

(a) the date the impression is taken in the case of dentures or fixed bridges.

(b) the date the preparation of the tooth is begun, in the case of crown work.

(c) the date the work on the tooth is begun, in the case of root canal therapy.

(d) the date the work is done, in the case of any other work.

NOTE: The charges in (a), (b), and (c) above will be covered only if the work is completed within 30 days after a person's coverage ends.

GENERAL INFORMATION

ACTIVE WORK/ACTIVELY AT WORK

This term means the performance of all the duties that pertain to your work at the place where it is normally done, or where it is required to be done by your Employer.

DENTIST

This term means a licensed dentist acting within the scope of his or her license. This includes a physician furnishing covered dental services which he or she is licensed to perform.

CHARGES/FEES/EXPENSES

The terms charges, fees, or expenses as they relate to health care will not include any amount:

(a) for a service or supply not generally accepted in health care practice as needed in the diagnosis or treatment of the patient, even if ordered by a doctor;

(b) for repeated tests which are not needed, even if ordered by a doctor;

(c) more than what is reasonable and customary in the locale where incurred, as determined by the Participating PPO. – Sele-Dent, Inc.

PLAN

This term means any plan that provides dental care coverage written on an expense incurred basis with which coordination is allowed.

"Plan" may include:

(a) any group insurance, or any other method of coverage for persons in a group.

(b) an insured arrangement of group coverage.

(c) group coverage through the Fund and other prepayment, group practice and individual practice plans.

(d) any governmental plan, but not including a state plan under Medicaid

THIS PLAN

This term means that part of the Group Plan which provides benefits for dental care.

PLAN ADMINISTRATOR

United Benefit Fund, 40-26 235th Street, Douglaston, N.Y. 11363

PRIMARY PLAN

This term means This Plan, or any other Plan, which determines its dental care benefits for a covered person without taking into account any other Plan. A Plan is Primary if either:

(i) the Plan does not have a Non-Duplication of Benefits provisions like This Plan; or

(ii) the Plan, in accord with Order of Payment, would determine its benefits first.

SECONDARY PLAN

This term means any plan which is not a Primary Plan.

NO-FAULT MOTOR VEHICLE PLAN

This term means motor vehicle plan which is required by the law and provides dental care payments which are made, in whole or in part, without regard fault. A person subject to such law who has not complied with the law will be deemed to have received the benefits required by the law.

ORDER OF PAYMENT

When a person is covered under two or more plans, the rules that follow will decide the order in which the plans will pay benefits.

1. A plan which does not have a provision like this Non-Duplication of Benefits will pay before this Plan.
2. A plan which covers a person other than as a dependent will pay before a plan which covers a person as a dependent.

3. A plan which covers a person as a dependent of a person whose date of birth occurs earlier in a calendar year will pay before a plan which covers the person as a dependent of a person whose date of birth occurs later in a calendar year provided that:

   (i) if said dates of birth are the same, the plan which has covered a person for the longest time will pay first.

   (ii) if the other plan does not have the rule described above, 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 in the other plan will determine the order of benefit.

In item 3 above, date of birth means day and month of birth. It does not mean year of birth. However, if the person is a dependent child of divorced or separated parents, the order will be as follows:

(a) first, the plan of the parent with custody of the child;

(b) then, the Plan of the spouse of the parent with custody of the child;

(c) finally, the Plan of the parent not having custody of the child.

However, if there is a court decree which sets forth a financial duty for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any period year during which any benefits are actually paid or provided before the entity has the actual knowledge.

4. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that person's dependent) are determined before those of a plan which covers such person as a laid-off or retired employee (or as that person's dependent).

5. If these four rules do not decide which plan will pay its benefits first, the plan which has covered the person for the longest time will pay first. The length of time a person has been covered under a Plan is determined by the following:

   a. Two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

   b. The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, then it is measured from the date the claimant first became a member of the group.

To administer claims, the Plan Administrator, without the consent of any person, will have the right:

(a) to give or to get any data needed to determine benefits under this provision; and each person claiming benefits under a Plan must give the Plan Administrator any data needed to pay the claim.

(b) to pay an organization for the payment made under its Plan which should have been paid by the Plan Administrator. Amounts so paid will be deemed benefits paid under this Plan; and to the extent so paid there will be no more liability under this Plan. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

(c) to recover any excess if the amount paid is more than it should have paid under this provision from one or more of:

(i) The persons it has paid or for whom it has paid;

(ii) Insurance companies; or

(iii) Other organizations.

A Secondary Plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the Primary Plan, to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by the Primary Plan. Nothing in this provision shall be interpreted to require a Plan to reimburse a covered person in cash for the value of services provided by a Plan which provides benefits in the form of services.

WHEN COVERAGE ENDS

Your coverage ends when any of the following events occur:

(a) you leave your employ.

(b) you are no longer eligible.

(c) the Group Plan ceases.

A dependent's coverage ends when any of the following events occur:

(a) your coverage ends.

(b) that dependent is no longer an eligible dependent.

NOTE: If you cease active work, ask if arrangements may be made to continue coverage. Contact your Plan Administrator, Sele-Dent, Inc.

COBRA

On April 7, 1986, the Consolidated Omnibus Reconciliation Act **(COBRA)** of 1985 was signed into law. The provisions of the federal law are outlined below

OPTIONAL CONTINUANCE OF DENTAL COVERAGE

Special Continuance of Employee and Dependent Coverage

If your coverage ends, you may elect to continue coverage for a maximum period of eighteen months under the Group Plan for you and your dependents, provided that the coverage ends due to:

(a) lay-off;

(b) a reduction in the scheduled work hours per week;

(c) voluntary termination of employment with your Employer; or

(d) discharge from your employ (other than for gross misconduct).

United Benefit Fund will notify you of your right to continue coverage within 45 days of the occurrence of an above event. If your dependent's coverage ends, he or she may elect to continue coverage for a maximum period of thirty-six months under the Group Plan.

(a) Your dependent spouse may elect to continue coverage on his or her own behalf and on that of any dependent children whose coverage would otherwise end, provided that the coverage ends due to: (i) your death; or (ii) your divorce or legal separation.

(b) Your dependent child whose coverage would otherwise end, may elect to continue coverage on his or her own behalf, provided that the coverage ends due to the death of the employee when there is no surviving parent, or the child's marriage or attainment of the age limit.

You or your dependent must notify your Employer of the occurrence of the events shown in (a) ii or (b) above. The notice should be given to your Employer as soon as is reasonably possible after the date the event occurred.

Within 45 days of receipt of notice that an event ending a dependent's coverage has occurred, United Benefit Fund shall send notice to your dependent of the right to continue the coverage. To continue coverage, you or our dependent must apply in writing to United Benefit Fund within 60 days of the later of (1) the date the coverage ends; and (2) the date you or your dependent receive notice of the right to continue the coverage.

You or your dependent must pay the required amount, if any, for the continued coverage. United Benefit Fund will inform you of the monthly amount to be paid. You or your dependent must also pay such amount for any period of continued coverage which began prior to the election of such continuance. This amount must be paid within 45 days after the date the continued coverage is elected. The continued coverage will begin on the date after the date coverage would have ended. It will end when the first of the following events occur:

(a) the Group Plan terminates;

(b) the end of the period allowed for continued coverage;

(c) the end of the period for which contributions were paid;

(d) the date you or your dependent become covered under a group plan;

(e) the date your or your dependent become eligible for Medicare;

(f) the date your former spouse remarries and becomes covered under a group plan.

DENTAL COVERAGE

On receipt of due proof of claim, Dental Benefits are payable to you or your dentist.

General Claims Rules

Under the **Employee Retirement Income Security Act of 1974 (ERISA),** as amended, claims have been divided into several categories: Pre-service claims, Urgent Pre-service Care claims, Post-service claims, Concurrent care claims, Improper claims and Incomplete claims.

Pre-service only applies to benefits that require approval prior to obtaining care. It does not apply to courtesy reviews of claims.

Urgent Pre-service Care claims are claims that require approval prior to obtaining care and where, in the opinion of the treating physician with knowledge of the patient's condition, failure to make a swift determination would seriously jeopardize the claimant's life, health or ability to regain maximum function or could subject the patient to severe pain that could not be adequately managed without the care or treatment requested.

Post-service claims are any claims that are neither a Pre-service or Urgent Care claim.

Concurrent claims are claims, which are reviewed during the ongoing course of approved treatment or after the certain number of treatments already approved by the Fund has expired, and which could result in a reduction of benefits.

An **Incomplete claim** is one that is missing information necessary for a determination to be made (i.e., no CPT code).

Improper claim is a pre-service request, which is not filed in accordance with the Plan's claim filing procedures.

Under ERISA, the Plan must respond to an Urgent Pre-service request within 72 hours after receipt of a proper and complete claim. If the Fund receives an incomplete claim, you will be notified of the defect and of the specific information needed for processing within 24 hours of receipt. You then have 48 hours to provide the missing information. Once the requested information is received, the Fund will then render a decision within 48 hours of receipt of the information. If the requested information is not received, the Fund will render a decision within 48 hours of the expiration of the period within which you are to submit the requested information. To file an Urgent Pre-service claim, you may send your request to United Benefit Fund or you may telephone United Benefit Fund. Be sure to indicate on the fax coversheet that this is an Urgent claim. You will receive a decision according to the previously stated time frames.

The Fund will render a decision on all other proper and complete Pre-service claims within 15 days of receipt. If the Fund receives an incomplete Non-urgent Pre-service claim, the Plan Administrator will notify you of the defect within the initial 15-day period. You then have 45 days to provide the missing information. The Fund will render an initial determination of the claim within 15 days of receipt of the required additional information, provided it is received within the 45-day period. If the information is not provided, or if it is provided after the expiration of the 45-day period, the Fund will render its determination on the claim within 15 days from the expiration of the 45-day period, or within 15 days of the receipt of the required information, whichever date is earlier.

If the Fund receives an Improper Non-urgent Pre-service claim, you will receive notice of the defect and the procedures to be followed within 5 days of receipt. However, this will only apply if the original request contains the claimant's name and ID, the specific medical condition, and the specific treatment, service or product requested.

For Post-service claims, the Fund will render an initial determination within 30 days of receipt of a proper and complete claim. If the claim is incomplete, you will receive notification of the defect and of the information required within the initial 30-day period. You then have 45 days to provide the missing information. If the information is not provided or if it is provided after the expiration of the 45-day period, the Fund will render its initial determination within 15 days from the expiration of the 45-day period, or within 15 days of the receipt of the required information, whichever date is earlier. In all other instances, the Fund will make the initial determination within 15 days from receipt of the information.

Should the Plan review a claim for Concurrent care, which would result in a reduction and/or denial of treatment, you or your eligible dependent(s) will be notified of the decision to terminate and/or reduce treatment before the reduction or termination would take effect. You will receive this notification with sufficient time to allow you to appeal this determination and review the decision on your appeal prior to the treatment being reduced or terminated. Additionally, should you or your eligible dependent(s) request to extend a course of treatment beyond the period of time or number of treatments for a claim involving urgent care, a determination must be made by the Fund as soon as possible. You will be notified of the Plan's determination, whether adverse or not, within 24 hours after receipt of your claim, provided the claim is submitted at least 24 hours prior to the expiration of the previously allowed for period of time and/or number of treatments.

CLAIM APPEAL PROCEDURES

If your claim for benefits is denied in whole or in part for any reason, the Plan will send you written notice of such denial. The notice will include the specific reason or reasons for the denial, the special reference to pertinent Plan provisions on which the denial is based, a description of any additional material or information necessary for you to complete your claim (if applicable), and an explanation of why such material or information is necessary (if applicable), and appropriate information as to the steps to be taken if you wish to appeal the denial of your claim.

If a denial takes place, you or your authorized representative may appeal, in writing, to the Board of Trustees within 180 days after you receive the Fund's denial notice. Any such appeal must be sent to the attention of the Board of Trustees and mailed to the Fund office. For an appeal of an urgent pre-service claim, ERISA permits receipt of said appeal orally or in writing via facsimile and allows for the transmission of information by and between the Plan and the claimant via telephone, facsimile or other available expeditious means.

Your appeal and/or correspondence (or your representative's correspondence) must include the following statement. "I AM WRITING IN ORDER TO APPEAL THE TRUSTEE'S DENIAL OF BENEFITS FOR __________
DATED ____________________. If this statement is not included, then the Trustees may not understand that you are making an appeal as opposed to general inquiry. Your appeal should state the reasons why you believe you are entitled to the

benefit you claim and you may submit additional information relating to the claim should you believe it is pertinent to your position. You may also request, free of charge, copies of all documents, records and other relevant information, regardless of whether it was relied upon, to make the initial determination. You may have a representative present your position on appeal. However, should you desire to utilize a representative, you must inform the Trustees, in writing, of this fact prior to any scheduled hearing on the subject. The Trustees will not address any representative unless they are absolutely sure that he/she is your authorized representative.

Should you desire to appeal an adverse decision of a Post-Service claim, said appeal will be reviewed by the Board of Trustees, or a Committee of the Trustees, at their next regularly scheduled meeting immediately following receipt of your appeal, unless your appeal was received by the Fund Office less than 30 days before the meeting. In such instance, your appeal will be reviewed at the second regularly scheduled meeting following receipt of your appeal, if applicable. However, in all circumstances, a decision on appeal will be rendered within 60 days of receipt of your appeal. Written notice of the decision on your appeal will be sent as soon as possible, but not later than 5 days after the decision is made.

Should you desire to appeal the denial of an Urgent Pre-Service claim, as defined by ERISA, a decision will be made within 72 hours after receipt of such appeal. All appeals of Non-urgent Pre-service claims will be made within 30 days of receipt of the appeal.

If the denial of services is predicated on the issue of medical necessity or experimental treatment, ERISA provides for a review by a health care professional not associated with the person who gave advice to the Plan which resulted in the denial of the claim and who has appropriate training and experience in the field involved in the medical judgment.

If the request for review involves a claim for benefits that are provided by an insurance company, insurance service or other similar organization, such company, service or organization shall make the review and final decision.

Since the Trustees and/or their designee (the insurance company, service or organization) have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Plan, the final decision of the Trustees, or the insurance company, service or organization, with respect to their review of your appeal shall be final and binding upon you. (See section "Plan Interpretation and Determinations" below.)

If the decision on appeal upholds the initial benefit denial, in whole or part, you may bring a civil action against the Fund under §502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"). Should you wish to avail yourself of an Urgent Pre-service appeal, contact United Benefit Fund.

PLAN INTERPRETATIONS AND DETERMINATIONS

Notwithstanding any other provisions of this Plan, the Board of Trustees is responsible for interpreting the Plan and for making determinations under the Plan. In order to carry out this responsibility, the Trustees shall have exclusive authority and discretion:

- To determine whether an individual is eligible for any benefits under the Plan;
- To determine the amount of benefits, if any, an individual is entitled to from the Plan;
- To determine or find facts that are relevant to any claim for benefits from the Plan;
- To interpret all of the Plan's provisions;
- To interpret all of the provisions of the Summary Plan Description, and underlying Plan documents;
- To interpret the provision of any collective bargaining agreement or written participation agreement involving or impacting the Plan;

- To interpret the provisions of the Trust Agreement governing the operation of the Plan;
- To interpret all of the provisions of any other document or instrument involving or impacting the Plan;

- To interpret all of the terms used in this Plan and all of the other previously mentioned agreements, documents and instruments and;

- To amend, modify, or discontinue all or part of the Plan whenever, in their sole and absolute discretion, conditions so warrant.

All such determinations and interpretations made by the Trustees:

Shall be final and binding upon any individual claiming benefits under the Plan and upon all employees, all employers, the Union, and any party who has executed any agreement with the United Benefit Fund,

Shall be given deference in all courts of law to the greatest extent allowed by applicable law; and

Shall not be overturned or set aside by any court of law unless the court finds that the Trustees, or their designee, acted in an arbitrary and/or capricious manner.

Incompetence

If the Trustees determine that a person entitled to benefits from the Plan is unable to care for his/her affairs because of illness, accident, or incapacity (either physical or mental), payment which would otherwise be made to that person shall be made to that person's duly appointed legal representative. In the event no legal representative shall have been appointed, such payment shall, in the discretion of the Trustees, be made to that person's spouse, child or such person who shall have care and custody of that person.

Cooperation

Every claimant will furnish to the Trustees all such information, in writing, as may be reasonably requested by them for the purpose of establishing, maintaining and administering the Plan. Failure on the part of the claimant to comply with such requests promptly and in good faith will be sufficient grounds for delaying payments of benefits. The Trustees will be sole judges of the standard of proof required in any case, and they may, from time to time, adopt such formulas, methods and procedures as they consider advisable.

Mailing Address of Claimant

If a claimant fails to inform the Trustees of a change of address and the Trustees are unable to communicate with the claimant at the address last recorded by the Trustees and a letter sent by first class mail to such claimant is returned, any payments due the claimant will be held without interest until payment can be successfully made. Be sure to inform the Trustees immediately of any change of address.

Recovery of Payment

The Trustees have the right to recover any overpayment or payment made in error to you or to a third party on your behalf, or any benefit payments made in reliance on any false or fraudulent statement, information or proof submitted. Such a recovery may be made by reducing other benefit payments made to you or on your behalf, by commencing a legal action or by such other methods as the Trustees, in their sole and absolute discretion, determine to be appropriate.

SUBROGATION

(Claims Involving Third-Party Liability)

This provision applies to all participants and their covered dependents with respect to all of the benefits provided under 1. For the purposes of this provision, the terms "you" and "your" refer to all participants and covered dependents.

Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for your illness or injury or is otherwise responsible for your medical bills. The rules in this section govern how this is all benefits in such situations.

These rules have two purposes. First, the rules ensure that your benefits will be paid promptly. Often, where there are questions of third-party liability, many months pass before the third party actually pays. These rules permit this Plan to pay your covered expenses and provide any other benefits to which you are entitled until your dispute with the third party is resolved.

Second, the rules protect this Plan from bearing the full expense in situations where a third party is liable. Under these rules, it is determined that a third party is liable in any way for the injuries giving rise to these expenses, or that the Third Party settles the claim which gave rise to the injuries without an admission of guilt, this Plan must be reimbursed for the relevant benefits it has advanced to you out of any recovery whatsoever that you receive that is, in any way, related to the event which caused you to incur the medical expenses.

Rights of Subrogation and Reimbursement

If you incur covered expenses for which a third party may be liable, or if you become entitled to other benefits as a result of the same events which caused you to incur the covered expenses, you are required to advise the Plan of that fact.

In addition to its subrogation rights, the Plan has the right to be reimbursed for payments made to you or on your behalf under these circumstances. The Plan must be reimbursed, in full, from any settlement, judgment, or other payment that obtain from the liable third party. Other expenses, including attorneys' fees, cannot be taken out of the payment.

Fund shall have a lien on any amount received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the Fund under this Section, and any such amount shall be deemed to be held in trust by you or your dependent for the benefit of the Fund until paid to the Fund.

Trustees may, in their sole and absolute discretion, require you (or your authorized representative if you are a minor or capacitated) to execute this Plan's lien forms before this Plan pays you any benefits related to such expenses.

If the Trustees have required execution of the Plan's lien forms, no benefits will be provided unless you and your attorney (if any) sign the form. You must also notify the Plan if you retain another attorney or an additional attorney since that attorney may be required to execute the form. IN NO EVENT SHALL THE FAILURE OF THE TRUSTEES TO REQUIRE EXECUTION OF THE LIEN FORMS DIMINISH OR BE CONSIDERED A WAIVER OF THE PLAN'S RIGHTS OF SUBROGATION AND REIMBURSEMENT.

Assignment of Claim

The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to this Plan. If this Plan recovers, from the third party, any amount in excess of the benefits paid to you, plus the expenses incurred in making the recovery, then the excess will be paid to you.

Failure to Disclose and/or Cooperate

If you fail to tell this Plan that you have a claim against a third party; if you fail to assign your claim against the third party to this Plan when required to do so (and to cooperate with the Plan's subsequent recovery efforts); if you fail to require any attorney you subsequently retain to sign the Plan's lien forms; if you and/or your attorneys fail to reimburse this Plan out of any payment you obtain from the third party; and/or if you fail to fully reimburse the Plan (out of any settlement you receive, or otherwise, even if this Plan reduces the amount of its lien or otherwise limits its rights); then you are personally liable to this Plan for the reimbursement owed to this Plan by the third party. The plan may offset the amount you owe from any future benefit claims, or if necessary, take all legal action available against you to it to recoup its money.

The 1996 Health Insurance Portability Act (HIPPA) has Privacy Regulations. Your dental plan is a covered entity under HIPPA. Therefore no "Protected Health Information" (PHI) may be disclosed to any individual, unless it is the patient. If you chose to share your PHI with your family, this must be done with a written authorization designating such information. If you have any questions regarding HIPPA, please contact

COVERED SERVICES ($10 Co-Pay)			
D0120	PERIODIC ORAL EXAM	D2722	CROWN RESIN NOBLE METAL
00150	COMPREHENSIVE ORAL EXAM	D2740	CROWN PORCELAIN CERAMIC
D140	LIMITED ORAL EXAM	02751	CROWN PORCELAIN PREDOM BASE METAL
00210	X-RAYS COMPLETE SERIES	D2752	CROWN PORCELAIN NOBLE Mt AL
D0220	X-RAYS PERIAPICAL 1ST FILM	D2750	CROWN PORCELAIN HIGH NOBLE METAL
D0230	X-RAYS PERIAPICAL EA ADDL FILM	D2791	CROWN FULL CAST PREDOM BASE METAL
D0240	X-RAYS OCCLUSAL FILM	D2792	CROWN FULL CAST NOBLE METAL
D0272	X-RAYS 2 BITEWINGS	D2790	CROWN FULL CAST HIGH NOBLE METAL
D0274	X-RAYS 4 BITEWINGS	D2794	CROWN TITANIUM
D0330	X-RAYS PANORAMIC FILM	D2910	RE-CEMENT INLAY
D0360	CONE BEAM CT SCAN	D2920	RE-CEMENT CROWN
D1110	DENTAL PROPHYLAXIS - ADULT	D2930	STAINLESS STEEL CROWN
D1120	DENTAL PROPHYLAXIS - CHILD	D2940	SEDATIVE FILLING
D1206	TOPICAL APPLICATION FLUORIDE VARNISH	D2951	PIN RETENTION - PER TOOTH
01208	TOPICAL APPLICATION FLUORIDE NON-VARNISH	D2952	CAST POST AND CORE
D1351	SEALANT PER TOOTH	D2954	PREFABRICATED POST AND CORE
D1510	SPACE MAINTAINER FXD UNILAT	D3110	PULP CAP DIRECT
D1515	FIXED BILAT SPACE MAINTAINER	D3120	PULP CAP INDIRECT
D2140	AMALGAM I SURFACE	D3220	THERAPEUTIC PULPOTOMY
D2150	AMALGAM 2 SURFACES	D3310	ROOT CANAL ANTERIOR

COVERED SERVICES ($10 Co-Pay), Con't			
D2I60	AMALGAM 3 SURFACES	D3320	ROOT CANAL BICUSPID
D2330	COMPOSITE I SURFACE	D3330	ROOT CANAL MOLAR
D233I	COMPOSITE 2 SURFACES	D333I	TREATMENT OF ROOT CANAL OBSTRUCTION
D2332	COMPOSITE 3 SURFACES	D3332	INCOMPLETE ENDODONTIC THERAPY
D2391	RESIT BASED COMPOSITE - ONE SURFACE	D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS
D2392	RESIT BASED COMPOSITE - TWO SURFACE	D3346	RETREATMENT / PREVIOUS ROOT CANAL THERAPY ANTERIOR
D2335	COMPOSITE 4 OR MORE SURFACES	D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY MOLAR
D2510	INLAY METALLIC I SURFACE	D3348	RETREATMENT / PREVIOUS ROOT CANAL THERAPY BICUSPID
D2520	INLAY METALLIC 2 SURFACES	D3410	APICOECTOMY
D2530	INLAY METALLIC 3 SURFACES	D4210	GINGIVECTOMY/PLASTY PER QUAD
D2542	ONLAY METALLIC 2 SURFACES	D4240	GINGIVAL FLAP PROCEDURE
D2543	ONLAY METALLIC 3 SURFACES	D4260	OSSEOUS SURGERY PER QUAD
D2544	ONLAY METALLIC 4 OR MORE SURFACES	D4263	BONE REPLACEMENT GRAFT 1ST SITE
02710	CROWN RESIN	D4264	BONE REPLACEMENT GRAFT EA ADDL
D2720	CROWN RESIN HIGH NOBLE METAL	D4341	PERIO SCALING / ROOT PLANNING QUAD
D2721	CROWN RESIN PREDOM BASE METAL	D4381	ARRESTIN

COVERED SERVICES ($10 Co-Pay), Con't.			
D4910	PERIO MAINTENANCE	D6740	ABUTMENT PORCELAIN
D5110	COMPLETE DENTURE MAXILLARY	D6751	ABUTMENT PORCELAIN/PREDOM BASE METAL
D5120	COMPLETE DENTURE MANDIBULAR (Lower)	D6752	ABUTMENT PORCELAIN NOBLE METAL
D5130	IMMEDIATE DENTURE MAXILLARY	D6750	ABUTMENT PORCELAIN HIGH NOBLE METAL
D5140	IMMEDIATE DENTURE MANDIBULAR	D6791	ABUTMENT FULL CAST PREDOM BASE
D5211	PRTL DENT MAX W/CLASPS ACRYLIC	D6792	ABUTMENT CAST NOBLE METAL
05212	PRTI. DENT MAND W/CLASPS ACRYLIC	D6790	ABUTMENT CAST HIGH NOBLE METAL
D5213	PARTIAL DENT MAX W/CLASPS CAST	D6710	ABUTMENT RESIN
D52I4	PARTIAL DENT MAND WI/CLASPS CAST	D6721	ABUTMENT RESIN PREDOM BASE METAL
D5281	REMOVAL UNILATERAL PARTIAL	D6722	CROWN RESIN WITH NOBLE METAL
D5410	ADJUST COMPLETE DENTURE MAX	D6740	ABUTMENT PORCELAIN
D5411	ADJUST COMPLETE DENTURE MAND	D6751	ABUTMENT PORCELAIN/PREDOM BASE METAL
D5421	ADJUST PARTIAL DENTURE MAX	D6752	ABUTMENT PORCELAIN NOBLE METAL
D5422	ADJUST PARTIAL DENTURE MAND	D6750	ABUTMENT PORCELAIN HIGH NOBLE METAL
D5510	REPAIR RESIN DENTURE BASE	D6790	ABUTMENT CAST HIGH NOBLE METAL
D5520	REPLACE BROKEN TEETH PER TOOTH	D6791	ABUTMENT FULL CAST PREDOM BASE
D5650	ADD TOOTH TO PARTIAL DENTURE	D6792	ABUTMENT CAST NOBLE METAL
D5660	ADD CLASP TO PARTIAL DENTURE	D6930	RE-CEMENT BRIDGE
D5710	DENTURES REBASE CMPLT MAX	D6973	CORE BUILD UP INCLUDING PINS
D5711	DENTURES REBASE CMPLT MAND	D6974	ABUTMENT TITANIUM
D5750	RELINE COMPLETE DENT MAX LAB	D7140	EXTRACTION SINGLE

COVERED SERVICES ($10 Co-Pay), Con't.			
D5751	RELINE COMPLETE DENT MAND LAB	D7210	SURGICAL REMOVAL ERUPTED TOOTH
D5760	RELINE PARTIAL DENT MAX LAB	D7220	SOFT TISSUE IMPACTION
05761	RELINE PARTIAL DENT MAND LAB	D7230	PARTIAL BONY IMPACTION
D6205	PONTIC RESIN	D7240	FULL BONY IMPACTION
D6251	PONTIC RESIN PREDOM BASE METAL	D7241	DIFFICULT FULL BONY IMPACTION
D6245	PONTIC PORCELAIN	D7285	BIOPSY OF ORAL TISSUE HARD
D6241	PONTIC PORCELAIN PREDOM BASE METAL	D7286	BIOPSY OF ORAL TISSUE SOFT
D6242	PONTIC PORCELAIN NOBLE METAL	D7310	ALVEOLOPLASTY WITH EXTRACTION /QUAD
D6240	PONTIC PORCELAIN HIGH NOBLE METAL	D7320	ALVEOLOPLASTY WITHOUT EXTRACTION /QUAD
D6211	PONTIC CAST PREDOM BASE METAL.	D7510	INCISION & DRAINAGE OF ABSCESS
D6212	PONTIC CAST NOBLE METAL	D7960	FRENECTOMY
D6210	PONTIC CAST HIGH NOBLE METAL.	D9110	PALLIATIVE TREATMENT
D6214	PONTIC TITANIUM	D9222	GENERAL ANESTHESIA FIRST 15 MINS
D6252	BRIDGE RESIN WITH NOBLE METAL	D9223	GENERAL ANESTHESIA EACH ADD 15 MINS
D6710	ABUTMENT RESIN	D9243	IV SEDATION PER 15 MIN
D6721	ABUTMENT RESIN PREDOM BASE METAL	D9310	CONSULTATION BY SPECIALIST
D6722	CROWN RESIN WITH NOBLE METAL		