



Dental

Plan Document

2008

BHP MEMBERS

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I. Welcome to BHP

This Dental Plan Document describes the dental benefits provided by the Butler Health Plan (the Plan). It explains who can be covered, how payments are made, how to file a claim and other important information about how your Plan works. It contains a schedule of dental benefits covered by the Plan. Check the BHP web site <http://www.butlerhealthplan.org> for the most up to date issue of the Dental Plan Document.

If you have questions about the exact meaning of language or terms, or if you have a question that is not covered in this Dental Plan Document, please call the Claim Administrator. BHP has hired a Claim Administrator to process claims and answer your questions regarding the Plan.

The Claim Administrator is accessible 24 hours a day, seven days a week through an automated telephone system or the web site. Customer service representatives are available during regular business hours to take your calls. Have the Employee Participant's ID Number and the claim information available when you call regarding a specific claim.

The Claim Administrator information is:

Allied Benefit Systems, Inc.
P.O. Box 909786-60690, Chicago, IL 60690
Chicago, IL 60690
1-312-906-8080
1-800-288-2078 (Outside Illinois)
www.alliedbenefit.com

(This information is also on your ID card)

As a condition of enrollment, each Employee has consented and authorized any dentist, physician, supplier, hospital, pharmacy, insurance company, employer or organization to disclose any medical information concerning him or herself, or any Dependents, to the Butler Health Plan or its agents or contractors for the purpose of administering, supervising and monitoring the health Plan(s). As a further condition of enrollment, each Employee has consented to the subsequent disclosure of medical information concerning him or herself, or any Dependents, by Butler Health Plan or its agents or contractors to contractors who provide wellness, disease management, case management or other health and health care related services to Butler Health Plan and/or its participants. This consent shall be valid until revoked in writing by the Employee.

II. Schedule of Dental Benefits

Benefit Paid By Plan:

All Classes of Service are subject to percentages of usual & customary (U/C) or scheduled amounts payable for covered dental expenses:

CLASS I	Preventative	100%
CLASS II	Basic	80% after Deductible
CLASS III	Major	60% after Deductible
CLASS IV	Orthodontic	60%

Deductible:

Calendar year Deductible, per Employee, for Class II and Class III services: \$25

Calendar year Deductible, per Employee + 1 and Family, for Class II and Class III services: \$50

Maximum Benefit:

Maximum benefit each calendar year for Class I, II and III services: \$2,500

Lifetime maximum for orthodontic services (*per person*): \$1,800

III. What is Covered

Covered Charges

This plan provides dental benefits for covered charges. Covered charges are the actual cost charged to a covered person for Medically Necessary dental services and supplies or specified routine care, but only to the extent that the actual cost charged does not exceed Usual and Customary. In addition, to be a covered charge, a charge must be incurred for services and supplies, which are:

1. Provided under the direction of a Physician or Dentist, except as specifically provided;
2. Started and completed while a covered person is enrolled in this plan;
3. Specifically listed in the plan as a covered dental service or supply; not excluded or limited by any provision of this plan; and
4. Consistent with the standards and guidelines established by the American Dental Association.

Class I Services- Preventive

1. Routine oral exam, 2 per 12-month period
2. Bitewing x-rays, 2 sets for children under age 18 per 12-month period and 1 set for adults per 12-month period
3. Full mouth x-ray (including panoramic), 1 per 36-month period
4. Other intra – and extra oral x-rays
5. Routine cleanings (dental prophylaxis, twice per 12 month period)
6. Fluoride treatment, once per 12-month period
7. Sealants, limited to Dependents under age 14
8. Tests and lab work
9. Space maintainers
10. Emergency pain treatment

Class II Services- Basic

1. Fillings, basic restorations
2. Extractions
3. Recementing inlays, Crowns and Bridges
4. Endodontic services
5. Root canal therapy
6. Periodontal services
7. Oral surgery
8. Adjustments to Dentures or Bridges
9. Denture and Bridge repair
10. Denture relining and rebasing
11. Additions to Dentures
12. Alveoplasty
13. Biopsies
14. General anesthesia
15. Therapeutic antibiotic drug injection
16. Mouthguard for bruxism (one per person per Lifetime)

Class III Services- Major

1. Crowns
2. Gold foil restorations
3. Inlays
4. Onlays
5. Dentures, complete
6. Dentures, partial
7. Bridges
8. Implants

Class IV Services- Orthodontic

1. Comprehensive full banded orthodontic treatment
2. Other orthodontic treatment
3. Appliances for tooth guidance*
4. Appliances to control harmful habits* (other than mouthguard for bruxism – See Basic Services)
5. Orthodontic retention appliances*
6. Other orthodontic services

**Only one such appliance per individual per lifetime is considered a Dental Service provided for in this Schedule.*

IV. What is Not Covered

Exclusions

Covered charges do not include and the plan will not pay benefit for:

1. services performed solely for cosmetic reasons, including charges for personalization or characterization of Denture, porcelain or acrylic veneers on molars.
2. replacement of a Bridge or Denture, which meets or can be made to meet commonly held dental standards of functional acceptability.
3. services and supplies not provided by or prescribed by a Dentist, except that scaling or cleaning of teeth and topical application by a licensed Dental Hygienist if the treatment is rendered under the supervision and guidance of the Dentist.
4. any Experimental or Investigational treatment, procedure, facility, equipment, drug, device or supply
5. replacement of a lost or stolen Prosthetic Appliance.
6. spare or duplicate Prosthetic Appliances.
7. Dentures, Crowns, inlays, onlays, Bridgework, or other appliances or services to increase vertical dimension or stabilize periodontal involved teeth, or to restore the occlusion.
8. expenses incurred before coverage begins or after it ends
9. replacement of a Bridge or Denture within five years following the date of its installation unless (a) such replacement is made necessary by the placement of an original opposing full Denture or the extraction of natural teeth; or (b) the Bridge or Denture, while being worn, has been damaged beyond repair as a result of an Accidental Injury received while the patient is covered for Dental Expense Benefits.
10. diagnosis or treatment of conditions or dysfunction of the temporomandibular joint including but not limited to occlusal adjustments, joint manipulations, splint and appliances.
11. porcelain or acrylic veneers of Crowns or Pontics on or replacing the upper and lower first, second and third molars; bite registrations.
12. precision or other elaborate attachments for any appliance.
13. for services for which expenses are covered or obtained through any Workers' Compensation or similar law, by stipulation or otherwise.
14. to the extent that you or your Dependents are reimbursed, or entitled to reimbursement, or are in any way indemnified in whole or in part through any public program, charitable or governmental, as now existing, or under any law which may be enacted.
15. for charges by a hospital owned or operated by the United States Government, except in a foreign country, or for the treatment of a non-service connected Illness or disability in Veteran's Administration hospitals or covered expenses for care while confined in a military medical facility, which are incurred by a U.S. military retiree and his or her covered Dependents, if any.
16. for charges which you or your Dependents are not legally required to pay.
17. for charges that would not have been made had coverage not existed.
18. in excess of the Usual and Customary charge for the locality in which they are incurred
19. treatment or services for which under this Plan is prohibited by any law to which a covered person is subject at the time expenses are incurred
20. to the extent that they are otherwise payable as described under Coordination of Benefits.
21. charges for consulting by telephone, failing to keep a scheduled visit, completing a claim form or providing medical records.

22. services, supplies or care which, in the judgment of the plan administrator, are not Medically Necessary, except as expressly provided.
23. services or supplies outside the scope of the provider's license.
24. charges to the extent the plan administrator determines that they are duplicate charges, charges for a procedure which was incidental to a more complex procedure, charge which should be included with another code on the provider's bill or charges for services which cannot be performed on the same date of service.
25. services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
26. services of a provider who is a member of the patient's immediate family or who normally resides in the patient's household.
27. any Injury or Illness incurred by a covered person while engaged in civil disorder, an illegal occupation or the commission of attempted commission of an assault of felony. A person will be deemed to have engaged in these activities if the plan administrator determines that he has been so engaged, whether or not he has been charged or convicted.
28. treatment of any Illness or Injury sustained as a result of any act of war, declared or undeclared, while covered under this plan.
29. personal comfort items.
30. services and supplies obtained outside the United State if the patient traveled to that location to obtain the services or supplies or if the services or supplies could not be obtained legally provided in the United States.
31. court ordered services or supplies, unless they would also be covered without a court order.
32. services that a school system is required by law to provide.
33. postage, sales tax, late fees, interest or finance charges.
34. charges eligible for coverage under any other part of this plan or another plan sponsored by the Employer.

V. Who Can Be Covered

Coverage for an Employee

You, as an Employee of a Participating Employer, and your Dependents are eligible for coverage under the Butler Health Plan (the Plan) if you meet applicable requirements. In this section, “you” and “your” refer to the covered Employee only. (See Definitions—“You.”) In order to obtain coverage for yourself or any Dependent, you must take certain steps such as completing enrollment forms. You are eligible to enroll in the Plan if you work for a Participating Employer and you are a member of a group of Employees designated by your Participating Employer as eligible to participate, or if you are a full-time Employee of the Butler Health Plan. Consult with your Participating Employer to find out how to obtain coverage or if you have any questions about whether you or your Dependents are eligible for Plan coverage.

Coverage for Dependents

Your Dependents are also eligible to enroll in this Plan for as long as you yourself remain covered. The following may qualify as your Dependents:

Spouse

Your Spouse may qualify as your Dependent.

When Both Spouses Are Eligible

When you and your Spouse are both eligible Employees working for the same or different BHP Participating Employers, the two of you may select, as appropriate: Two Employee plans, two Employee +1 Plans, or two Family plans. If you select two Employee+1 or Family plans, the Plan Administrator will coordinate dental benefits according to the specified rules of Coordination of Benefits.

Child

Your Children may qualify as Dependents under the plan. In order for a Child (See Definitions—Child) to be eligible for Dependent coverage, the following requirements apply:

1. The Child must have the same principal place of residence as you for at least half of the year.
2. The Child must be unmarried.
3. The Child must rely on you for at least one half of the Child’s support.
4. The Child must be under 19 years of age, or if the Child is a Full-Time Student (See Definitions—Full-Time Student), 25 years of age. As required under tax law, if the Child is over the age of 18, or 23 if a Full-Time Student, then the Child must have the same principal place of residence as you and be a member of your household. A Full-Time student who is away at school is considered to reside with you as a member of your household.

5. An exception to the age requirement applies if your Child became disabled at any time before the Child turned 19 years of age or while the Child was enrolled as a Participant, including under COBRA Continuation Coverage (See “When Coverage Ends”— COBRA). If your Child is disabled, your Child will be eligible for coverage if the following requirements are met:
 - a. You enroll him/her and give the Claim Administrator satisfactory written medical certification of his/her handicap (at your expense) within 31 days after the later of either (1) his/her 19th birthday or (2) the date on which he/she would otherwise cease to be enrolled as a Participant or to be covered under COBRA continuation coverage; and
 - b. Thereafter, you give the Claim Administrator satisfactory written medical certification of his/her handicap (at your expense) from time to time upon request.

Be sure to let your Employer know when there is a change in any of your personal information, such as your marital status, the number of your Dependents, their names and birth dates, etc. This is your responsibility. We cannot know who your Dependents are unless you tell us.

VI. When Coverage Starts

Initial Enrollment

Once you have been hired as an eligible Employee of a Participating Employer, you qualify for enrollment in the Plan. In order to enroll, you will have to fill out an enrollment form and elect the type of coverage you wish to carry within 31 calendar days after your date of hire. Coverage for the Employee begins on the Employee's starting date or on another beginning date, as determined by the Participating Employer.

You will have to fill out an enrollment form within 31 calendar days after your date of hire naming each eligible Dependent for whom you want to obtain coverage. If you enroll one or more of your eligible Dependents in the Plan when you are hired, their coverage will begin on the same date as yours. For example, your Spouse and the Children you now have will be covered by the Plan at the same time as you if you enroll them as your Dependents when you are hired.

Open Enrollment

If you do not enroll yourself or any of your Dependents in the Plan when first eligible to do so, but you decide to do so at a later time, you will have to wait until the next Open Enrollment unless there is a qualifying event. The Open Enrollment is 30 days in the fall of each year. Please check with your Employer to find out for when the Open Enrollment is scheduled. Elections made during the Open Enrollment become effective on January 1 of the following year.

Special Enrollment

There are certain qualifying events that permit an employee to enroll in the Plan outside of the Open Enrollment. If you do not enroll yourself or any of your Dependents in the Plan when eligible to do so after a qualifying event, but you decide to do so at a later time, you will have to wait until the next Open Enrollment unless there is another qualifying event.

The following are qualifying events:

Acquiring a New Dependent

An Employee who is not covered by the Plan may elect to become covered when the Employee acquires a new Dependent. This includes marriage, birth, and adoption. Individuals who first become eligible for coverage as your Dependents while you are enrolled in the Plan may generally be enrolled for coverage as soon as they qualify. The following guidelines apply:

1. Employee or Employee+1 Coverage: If you enroll a Dependent within 31 days after he or she first becomes eligible, and you also make any necessary changes in your coverage election, Plan coverage will be effective as of the date on which the individual qualified as your Dependent. Please note that enrolling a new Dependent will also require a change in your coverage election if you currently have Employee or Employee+1 coverage.
2. Newborn Provision for Employee or Employee+1 Plans: Newborns are covered from the moment of birth as long as they are properly enrolled in the Plan within 60 days after birth; however, no claims will be paid for a newborn until the newborn is enrolled in the Plan. Please

note that enrolling a newborn will also require a change in your coverage election if you currently have Employee or Employee+1 coverage. You have 60 days after the birth of your child in which to enroll your child and change your coverage election. If enrollment, including any necessary coverage election, is not completed within this 60-day period, you will not be able to enroll your Dependent in the Plan until the next Open Enrollment.

3. Family Coverage: If you have family coverage, your new Dependents are covered from the moment they qualify. Newborns are covered from the moment of birth; however, please remember to enroll your Newborn or other new Dependent in the Plan within 60 days immediately following the birth or other qualifying event. No claims will be paid for a Newborn or other new Dependent, even if you have family coverage, until the Dependent is enrolled in the Plan.

Loss of Medical Coverage Under Another Dental Care Plan

You may qualify for Special Enrollment if you lose dental coverage because of any of the following events:

- your divorce;
- your legal separation;
- your Spouse's death;
- your spouse's termination of employment, or reduction in hours of employment;
- your relocating outside of an HMO's service area (only if there is no access to other coverage through the HMO);
- your reaching the Lifetime limit for all benefits under other coverage (the Special Enrollment period in this instance would be 31 days after the earliest date that a claim is denied due to reaching the lifetime limit).
- your plan no longer offering benefits to a class of similarly situated individuals even if the plan continues to provide coverage to other individuals.

If you chose not to enroll in the Plan because you were covered by your Spouse's dental care plan and if, for one of the reasons above, your Spouse's coverage ends or your coverage ends under your Spouse's plan, you can enroll yourself and your Dependents in this Plan within the 31-day period immediately after your Spouse's coverage has terminated. You may also qualify for special enrollment if you previously qualified for COBRA Continuation of Coverage under another plan, but COBRA coverage has been exhausted under that plan. If eligible for any of the above reasons, enrollment in the Plan will be effective no later than the first day of the first month beginning after the completed request for enrollment is received.

Note that Special Enrollment may also be available, under certain circumstances, to Employees who decline coverage without having coverage under another plan. For this provision to apply, the Employee must subsequently enroll in other coverage, lose that coverage, and in the interim have had an opportunity for Open Enrollment or Special Enrollment under this Plan, but again chose not to enroll. If eligible for this reason, enrollment in the Plan will also be effective no later than the first day of the first month beginning after the completed request for enrollment is received.

If you do not enroll within the 31 days immediately after coverage ends under your Spouse's plan, you will have to wait until the next Open Enrollment to enroll. It is your responsibility to notify your Employer of termination of coverage under your Spouse's plan within 31 days of termination.

VII. When Coverage Ends

Coverage ends for any Employee at midnight on the last day of the calendar month in which the Employee ceases to qualify for coverage under the Plan. Coverage ends for a Dependent at midnight on the day in which the Dependent ceases to qualify for coverage under the Plan.

Participant

A Participant ceases to qualify for coverage under the Plan upon the occurrence of any of the following events:

1. The Participant is no longer eligible to participate in the Plan. (See – “Who Can Be Covered”)
2. The Employee fails to make a required contribution.
3. The Plan is terminated.
4. The Participant enters the U.S. Armed Forces on active duty, subject to the continuation and reinstatement provisions of the Uniformed Services Employment and Reemployment Act of 1994, as amended.
5. In the case of a Dependent:
 - a. The Employee ceases to qualify for coverage; or
 - b. The Employee elects to discontinue coverage for the Participant.

Dependent

A Dependent ceases to qualify for coverage under the Plan upon the occurrence of any of the following events:

1. Marriage of the Dependent.
2. The Dependent’s 19th Birthday, unless the Dependent is a Full-Time Student or is an eligible disabled person.
3. The Dependent, over age 19, ceases to be a Full-Time Student, unless the Plan receives satisfactory evidence that the Dependent will continue his/her studies as a Full-Time Student within one semester of the Dependent’s graduation.
4. The Dependent’s 25th Birthday, unless the Dependent is an eligible disabled person.

Death of an Employee—Family Security Benefits

If you die while you are an active regular Employee of a Participating Employer, coverage for your covered Dependents can continue if they sign up for COBRA benefits. (See “When Coverage Ends”—COBRA). Your Dependents will not have to pay the monthly cost of their coverage for the first 12 months of the COBRA continuation period. After 12 months, your Dependents can be covered for an additional 24 months, but they will have to pay the full monthly cost of their coverage. Coverage for your Dependents during this time will be governed by the COBRA provisions.

Leaves of Absence, Reductions in Force, and Layoffs

If you are not working because of a lay-off, reduction in force, or approved leave of absence, your coverage *may* be continued depending on your Employer's rules. Check with your Employer's office to find out what happens to your dental care coverage in these circumstances.

Reinstatement of Coverage

If your coverage has ended because you did not make a required monthly contribution within 31 calendar days of its due date, you can have your coverage reinstated if you fill out an enrollment form for yourself and each Dependent you want to be covered. Your coverage will be subject to approval by your Employer and, if approved, your coverage will be effective according to your Employer's internal policies applicable to such situations.

Also, note that in addition to previously covered Dependent children continuing uninterrupted coverage by attaining Full-Time Student status, a dependent child over the standard limiting age but under the Full-Time Student limiting age may be immediately added to the Plan as an eligible Dependent if the child meets all other eligibility criteria and is a Full-Time Student at the time of initial eligibility. A dependent child who was formerly an eligible Dependent as a Full-Time Student, but who then became ineligible due to dropping of Full-Time Student status will be immediately reinstated as an eligible Dependent upon reinstatement of Full-Time Student status, providing he/she is under the limiting age for Full-Time Students and meets all other eligibility requirements. See also definition of "Full-Time Student."

Family and Medical Leave Act

An Employee who qualifies for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under the Plan for up to 12 weeks during any 12 month period. The following summary is informational only, and your entitlement to continuation coverage will be determined in accordance with the requirements of the FMLA.

Contributions

During this leave, the Employer will continue to pay the same portion of premium as if the Employee were active. The Employee will be responsible to continue payment for eligible Dependents' coverage and any remaining Employee contributions. If the covered Employee fails to make the required contribution during a FMLA leave within 30 days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

Reinstatement

If coverage under the Plan was terminated during an approved FMLA leave, and the Employee returns to active work immediately upon completion of that leave, Plan coverage will be reinstated on the date the Employee returns to active work as if coverage had not terminated, provided the Employee makes any necessary contributions and enrolls for coverage within 31 days of his/her return to active work.

Repayment Requirement

The Employer may require Employees who fail to return from a leave under FMLA to repay any contributions paid by the Employer on the Employee's behalf during an unpaid leave. This repayment will be required only if the Employee's failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or to events beyond the Employee's control.

Military Leaves

If you are absent from work due to military service, you may elect to continue coverage under the Plan (including coverage for enrolled Dependents) for up to 24 months from the first day of absence (or, if earlier, until the day after the date you are required to apply for or return to active employment with your Employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)). Your contributions for continued coverage will be the same as for a COBRA beneficiary, except that, if you are absent for 30 days or less, your contribution will be the same as for similarly situated active participants in the Plan.

Whether or not you continue coverage during military service, you may reinstate coverage under the Plan on your return to employment under USERRA. The reinstatement will be without any waiting period otherwise required under the Plan, except to the extent that you had not fully completed any required waiting period prior to the start of military service.

COBRA—Continuation of Coverage

The Plan includes a continuation of the dental coverage option, as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. The following summary is informational only, and your entitlement to continuation coverage will be determined in accordance with the requirements of COBRA.

Eligibility

A Participant may choose to continue dental coverage at his/her own expense upon the occurrence of any of the following events that would otherwise cause the Participant to lose coverage:

1. Death of the covered Employee.
2. Termination of the covered Employee's employment (other than termination for gross misconduct) or reduction of the covered Employee's employment.
3. Divorce or legal separation of the covered Employee from the employee's spouse.
4. A Dependent Child ceasing to meet the eligibility requirements of the Plan. (See "Who Can Be Covered"—Eligible Child)
5. The last day of leave under the Family and Medical Leave Act of 1993.
6. The call-up of an Employee reservist to active duty.

A Spouse or Dependent Child newly acquired during continuation coverage is eligible to be enrolled as a Dependent. The normal enrollment requirements of the Plan apply to enrollees during continuation coverage. A Dependent acquired and enrolled after the original qualifying event, other than a Child born to or placed for adoption with the covered Employee, is not eligible for a separate continuation coverage if a subsequent event results in the Dependent's loss of coverage.

Notification Requirements

When eligibility for continuation of coverage results from a Spouse being divorced or legally separated from a covered Employee, or from a Child's loss of Dependent status, the Employee or Dependent must notify the Employer of that event within 60 days of the event. Failure to provide such notice to the Employer will result in a forfeiture of the right to continuation of coverage.

If any of the events listed above occurs, you will get a notice from the Claim Administrator which will give you information about continuation of coverage. Each person who was covered under the Plan prior to the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. The coverage will be the same as the dental coverage for all active Employees covered by the Plan. You will have to decide before the end of 60 days from the date of the notice from the Claim Administrator whether or not you want to elect continuation of coverage. This 60 day period begins on the later of the following:

1. The date coverage under the Plan would otherwise end, or
2. The date the person receives the notice from the Employer of his or her rights to continuation of coverage.

Cost of Continuation Coverage

Your monthly cost will be an amount up to 102% of the monthly cost to provide coverage for active Employees and their families. Within 45 days after the date you notify the Employer that you have chosen to continue coverage, you must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continuation of coverage begins through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are to be made monthly, and are due in advance, on the first day of each month. If full payment is not received within 30 days of any due date, coverage will be canceled retroactively to the due date.

When continuation of coverage is elected and the contributions are paid within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for Dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

Subsequent Qualifying Events

Once you are covered under continuation of coverage, it is possible for a second qualifying event to occur, including:

1. Death of an Employee
2. Divorce or legal separation from an Employee
3. A Child's loss of Dependent status

If one of these subsequent qualifying events occurs, a Dependent may be entitled to a second continuation period. This period will in no event continue beyond 36 months from the date of the first qualifying event.

Only a person covered prior to the original qualifying event or a Child born to or placed for adoption with a covered Employee during a period of continuation coverage is eligible to continue coverage again as a result of a subsequent qualifying event. Any other Dependent acquired during continuation of coverage is not eligible to continue coverage as a result of a subsequent qualifying event.

End of Continuation Coverage

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen months from the date continuation of coverage began because of a reduction of hours or termination of employment of the Employee.
2. Thirty-six months from the date continuation began for Dependents whose coverage ended because of the death of the Employee, divorce or legal separation from the Employee, or a Child's loss of Dependent status.
3. The end of the period for which contributions are paid if the Participant fails to make a payment on the date specified by the Employer.
4. The date coverage under the Plan ends and the Employer offers no other group dental benefit plan.
5. The date the Participant first becomes entitled to Medicare after the qualifying event.
6. The date the Participant first becomes covered under any other group dental plan after the qualifying event.

Disabilities Occurring During Continuation Coverage

If you are disabled at the time you qualify for continuation coverage, or at any time within the first 60 calendar days after you become eligible for continuation coverage because you quit working for a Participating Employer or because you are no longer a regular Employee, the Plan coverage may be continued for up to 29 months or, in some cases, 36 months. In order to qualify for an extended period of continuation coverage:

1. Your disability must be determined under Title 2 (Old Age, Survivors and Disability Insurance) or Title 16 (Supplemental Security Income) of the Social Security Act, and
2. You must give your Employer written notice of your disability determination under the Social Security Act during the first 18 months of your continuation coverage and within 60 days after you receive notification of your disability determination from Social Security. If Social Security should determine that you are no longer disabled, you must give your Employer notice within 30 days after you receive notice of the determination.

If you meet the above conditions, Plan coverage will be continued from the date you quit working or your classification is changed until the first of the month more than 30 days after you receive a final determination from Social Security that you are no longer disabled. If another qualifying event should occur following your termination or change of classification (for example, a divorce), the maximum period for continuation coverage may be extended to 36 months. If Plan coverage is continued because of disability for longer than 18 months, you may have to pay an extra amount (up to 150% of the monthly cost of coverage) for each month of coverage after the 18th month.

Plan Coverage Can End Earlier.

It will stop immediately for any of the following reasons:

1. The Plan is terminated in its entirety.
2. You do not make a payment you are supposed to.
3. You become covered under any other group dental plan.
4. Your ex-husband or ex-wife remarries and becomes covered under another group dental plan.

VIII. How Claims Are Administered

How Payments Are Made

Deductible

Dental services are divided into Class I through IV services. Services in Classes II and III are subject to an annual Deductible. (See— “Schedule of Dental Benefits”)

Individual Deductible

The individual Deductible is the amount of covered charges that a covered person must pay each calendar year before the plan will pay benefits. Charges for any service or supply after the maximum benefit applicable to that service or supply has been reached will never be credited to a Deductible. The plan will never pay any benefits for any charge credited to the individual Deductible.

Family Deductible

The family Deductible is the maximum amount of covered charges that the plan will credit to the combined individual Deductibles of a participant and his covered Dependents in a calendar year. Once a participant and his covered Dependents have met the family Deductible, the plan will not credit any additional charges to any individual Deductible for those persons for the rest of that calendar year.

Deductible Carryover

Covered charges that a covered person incurs during October, November or December and that are credited to that person’s Deductible for that year will also be credited to his Deductible for the following year.

Co-Insurance

The Co-Insurance percentage is the percentage of covered charges that the Plan will pay once a covered person has met the individual or family Deductible. The Co-Insurance percentages differ depending on the type of service provided. (See—“Schedule of Dental Benefits”)

Maximum Benefit

The Plan will pay covered charges, up to a maximum of \$2,500 for Class I, II and III Services per person per year. The Plan will pay covered charges, up to a lifetime maximum of \$1,800 for Class IV orthodontic services per person during the entire time you are covered by the Plan.

In addition to the \$2,500 maximum benefit, some of the individual benefits provided by the Plan are limited to a maximum payment either on a calendar year basis or over the entire time you are covered by the Plan.

How to File a Claim

You must fill out and file a Claim Form before the Plan can pay its part for your care, service, or treatment. The Dentist, hospital or Physician from whom you receive services may fill out this claim form as a service to you. However, if the Dentist, hospital or Physician does not provide this service, you will be responsible for submitting the Claim Form. You can get these forms from your Employer's office. If you have any questions about how to fill out the form or where to send it, please inquire in your Employer's office or call our Claim Administrator. You cannot combine claims for more than one family member on the same Claim Form. You must complete a separate Claim Form for yourself and each Dependent who has covered charges. Canceled checks, balance due statements, photocopies, payment receipts, and cash register receipts cannot be accepted as a claim filing. The Claim Administrator may require you to submit dental records or other information or to be examined by a Physician of its choice when necessary to determine any claim.

All claims must be sent to our Claim Administrator address. (See—"Welcome to BHP")

Postservice Claims

A Postservice Claim is any claim for benefits under the Plan that is not a Preservice Claim. Postservice Claims may be filed by sending to the Claim Administrator completed claim forms and other needed information it reasonably requires to establish the claim within 90 days after the date the claims are incurred. All information regarding a Postservice Claim must be provided in writing or via an electronic transmission that the Plan is required by law to accept. Failure to file a claim within 90 days will not invalidate or reduce the claim if:

1. It was not reasonably possible to file the claim within that time; and
2. The claim was filed as soon as was reasonably possible.

In every case, the claim must be filed no later than 15 months from the date the claim was incurred. Claims are incurred on the date the service or supply is provided. Upon termination of the Plan or if an Employer or class of employees withdraws from the plan, claims must be filed within 30 days after termination. Claims that are not timely filed may be denied.

A Postservice Claim is considered filed on the date the Claim Administrator actually receives all of the following information:

1. Name and Member ID Number of the Employee and the name of the patient;
2. Name of the provider providing the service;
3. Date and duration of each service;
4. Charge for each visit or service and nature of treatment or service;
5. Diagnosis;
6. For services performed by other than a Dentist or oral surgeon, the name and professional status of provider of service.

To File a Claim for Doctors' Charges

You will have to fill out your part of a Claim Form and take it with you to your Doctor, who then must fill out the Doctor's part of the form. If you want the Plan to pay the Doctor directly, you must sign the "Authorization to Pay Benefits to Provider" statement on your claim form. If you do not sign this part,

you will have to pay your Doctor yourself and then the Plan will reimburse you for your covered charges. After you and your Doctor have completed the form, send it to the address on the form. The Claim Administrator will accept the Physician's claim form or computerized billing.

To File a Claim for Other Covered Charge

To be reimbursed for other charges you have paid yourself, fill out a Claim Form and attach the bills you have paid. It is important to send original invoices (bills) whenever possible. Please keep copies of all bills and correspondence for your records. Send all necessary information to the Claim Administrator.

Secondary Filing When Covered by Multiple Insurance Plans

When the Plan is the secondary payor for your Dependents, file a claim with the primary dental plan for payment of its benefit. Once you have received the Explanation of Benefits (EOB) from the primary payor, you may submit a Claim Form, with a copy of the Explanation of Benefits, to the Claim Administrator for secondary consideration of dental claims.

Notice of Benefit Determination

Each time you send in a claim, an Explanation of Benefits (EOB) form will be mailed to your home. This form explains the total amount billed, the amount paid, and who was paid. If any further information is needed, this request will also appear on the form. Please review this form carefully each time you file a claim so you will understand how your claim has been processed. If for any reason the Claim Administrator fails to act on your claim within the applicable time frames described in this section, the claim will be deemed to be denied.

Postservice Claims

For Postservice Claims, the Claim Administrator will notify the Participant of its decision no later than 30 days after it receives the claim. The Claim Administrator may extend this period for an additional 15 days if needed for reasons beyond its control by notifying the Participant within the initial 30-day period of the circumstances requiring the extension and the date of the expected decision.

If the extension is required because the Participant has not submitted information needed to decide the claim, the notice of extension will specifically describe the information required and give the Participant at least 45 days after receipt to provide it. The time for making a decision will not run from the date the notice of extension is sent to the Participant to the date the Participant provides the requested information.

Pretreatment Review

When charges for a proposed dental treatment (other than emergency treatment) are expected to exceed \$500, a dental treatment plan should be filed with the plan administrator before services are provided.

A determination will be made as to the benefits that will be payable for each dental service according to the terms of this Plan, and the claim form will be returned to the Dentist. (This "Pre-determination" of Benefits will take into account Usual and Customary, Benefit Limitations, and alternate procedures. You will know before any work begins just what your benefits should be).

Pretreatment Review is not recommended for courses under \$500.00, emergency treatment, routine oral examinations, x-rays, prophylaxis, or fluoride treatment.

Alternate Benefit Provision

If the claim administrator determines that more than one procedure could be performed to correct a dental condition, covered charges will be limited to the maximum allowance for the least expensive of the procedures that would provide professional acceptable results.

Appeal Procedure

If you file a claim and it is denied in whole or in part, or if your request for pre-certification is denied, and you disagree with the determination, you, or your authorized representative, can appeal the denial. A request for appeal must be in writing and must be sent by first class mail to the Claim Administrator. An appeal must be filed within 180 days after the Participant receives the Claim Administrator's notice of denial. An appeal will be considered filed on the date it is received. An appeal for claims filed beyond the timely filing date will not be considered. To appeal a decision, follow these steps:

1. Write to the Claim Administrator asking for reconsideration of your claim. Be sure to say why you think the payment decision is not correct—in other words, why you think your claim should be paid. (See—"Welcome to BHP"—for addresses.) You will receive a benefit determination on review from the Claim Administrator.
2. If you are not satisfied with the Claim Administrator's benefit determination on review of your appeal, write to the Claim Administrator asking to have the Plan Sponsor review your claim. Again, be sure to say why you think the payment decision is not correct—in other words, why you think your claim should be paid. You must send this request to the Claim Administrator within 180 calendar days after you receive your Explanation of Benefits Form, or within 30 days after you receive the benefit determination on review of your appeal from the Claim Administrator, whichever is later.

In connection with your appeal, you have the right to:

1. Submit written comments, documents, records and other information relating to the claim for benefits; and
2. Review and obtain without charge copies of documents, records and other information relevant to the claim being appealed.

The Claim Administrator will send the request to the Plan Administrator, and the Plan Sponsor will then make a full and fair review of the claim, taking into account everything you have submitted. The Plan Administrator may require the Participant to submit additional information to make the review.

In making a decision, the Plan Sponsor will:

1. Not give deference to the initial claim determination.
2. Not allow the same person who made the initial decision (or any subordinate of that person) to decide the appeal.
3. Consult with a health care professional on any appeal that involves the exercise of medical judgment. The health care professional will have training or experience in a field of medicine

appropriate to the questions raised on appeal. The professional will not be the same person consulted in connection with the original denial or any subordinate of that person. The Plan Administrator will identify the professionals consulted upon written request.

The Plan Sponsor will make a final decision in writing. That decision will be given:

1. within 30 days after the date the Claim Administrator receives the request for review.

Your appeal will be determined on its own merits at each stage of review, and the decision on your appeal will not be considered as setting any precedent or creating any future liability with respect to you or any other Participant. If for any reason the Plan Sponsor fails to act within these time frames, the appeal will be deemed to be denied. The decision of the Plan Sponsor is final and binding on all parties.

Plan Sponsors' Discretion

In considering appeals, and in all other matters related to the Plan, the Plan Sponsor has full authority and discretion to:

1. Administer, interpret, apply, and construe the Plan.
2. Determine all questions of fact and law that may arise under the Plan.
3. Determine all issues of coverage and eligibility.
4. Determine all benefits and authorized disbursements.

Lawsuits Against the Plan

A Participant who disagrees with the decision of the Plan Administrator after an appeal may have the right to bring a civil action under Section 502(a) of ERISA. No action at law or in equity may be brought to recover under the Plan:

1. If the Participant fails to exhaust the Appeal Procedure; or
2. Before final denial of a claim in accordance with that Procedure; or
3. Later than three years after the date the claim is finally denied.

IX. Other Important Points

Cost of Plan Coverage

The Plan is currently funded by premiums paid by your Employer to the Butler Health Plan Trust. The amount of the premium is based on a contract between BHP and your Employer. Your Employer may require you to pay some or all of the premium attributable to your coverage. Please check with your Employer's office to find out what, if any, part of the monthly premium you are required to pay. If you are represented by a union, your coverage is provided in accordance with the terms of your union contract.

The funds contributed to the Trust are used to pay the benefits described in this Plan Document and the costs of administering the Plan. Plan costs are based on the amount paid for claims over the preceding year(s), stop-loss insurance premiums, and administrative costs.

Plan Participants who are on continuation coverage (See "When Coverage Ends"—COBRA) are responsible for paying the entire monthly cost of their coverage.

All Participants in the Plan are responsible for paying:

1. Deductibles,
2. Co-payments and Co-Insurance, and
3. Charges for care, service, treatment, and supplies that are not covered by the Plan.

Third Party Liability

The Plan has reimbursement and subrogation rights. These rights apply when a Participant (You or any Dependent) suffers an Illness or Injury caused by the act or omission of a third party. If someone else is responsible for an Illness or Injury suffered by a Participant, the Participant is required to repay the Plan from any recovery the Participant receives. If necessary, the Plan is permitted to file a lawsuit in the Participant's name, or allow the Plan to intervene in a lawsuit the Participant files.

If the Plan pays Benefits because of an Injury or Illness, and if the Participant has the right to recover any amount for that Illness or Injury from any third party or insurer (including uninsured or underinsured motorist coverage), the Plan has a specific and first right of reimbursement from any full or partial payment the Participant obtains, up to the total amount of Benefits the Plan has paid, and regardless of whether the payment is the result of a court judgment, arbitration award, compromise settlement, or any other arrangement. Each Participant, by acceptance of such Benefits, agrees to the Plan's reimbursement and subrogation rights as described in this section, and grants the Plan an equitable lien on any recovery. The Plan's right to reimbursement exists regardless of the manner in which the recovery is structured or worded, and even if the Participant has not been fully compensated for all of the damages or expenses related to the Injury or Illness.

The Plan will not pay attorneys fees or costs associated with a claim or lawsuit without express written authorization from the Plan. The Plan's right to subrogation or reimbursement will not be affected or reduced by the make whole doctrine, the fund doctrine, the common fund doctrine, comparative/contributory negligence, collateral source rule, attorney's fund doctrine, regulatory diligence or any other equitable defenses.

Once a Participant has any reason to believe that the Participant may be entitled to recovery from any third party, the Participant must notify the Plan. At that time, the Participant must sign a subrogation/reimbursement agreement that confirms the Plan's subrogation rights and the Plan's right to reimbursement. If the Participant fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits until the agreement is signed; or, if the Plan nevertheless pays benefits, the Participant's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement. Each Participant has an obligation, because of the Plan's payments on the Participant's behalf, to cooperate with the Employer and the Claim Administrator.

Subrogation

The Plan shall have subrogation rights with respect to benefits paid for Illness or Injury caused by the act or omission of a third party. The Plan may make and pursue a claim directly against any party or insurer who is obligated to make payments of any kind as a result of the Illness or Injury.

Coordination of Benefits

Some of our Employees, or their Dependents, may also be covered by some other group dental plan. In this case, the Plan may pay part of the expense and the other plan may pay part of it, also. The benefits paid by all the plans covering any one person will be combined so that as much of the charge as possible will be paid. The combination of benefits paid by all of the plans covering any one person will not be more than the actual charge. To be sure all plans covering you and your Dependents are considered, we require that you let your Employer's office know whenever there are any changes in your personal information.

Some special rules are used to decide which plan will pay what part of the charge. The primary plan determines its benefits first. The secondary plan determines its benefits next. Here are the coordination of benefits rules:

1. If this Plan is the primary payor, it will determine and pay its benefits without regard to any other plan.
2. If this Plan is the secondary payor, it will pay the difference between what the primary plan has paid and your actual charge, subject to any maximum benefit provisions and exclusions which are part of this Plan. However, under no circumstances will this Plan pay more as secondary payor than it would have paid as primary payor.

The following coordination of benefits rules are used in determining which plan is the primary payor and which plan is secondary:

1. The following plans will automatically be considered a primary payor:
 - a. A Plan that does not have a coordination of benefits provision or a plan that coordinates benefits according to different rules.
 - b. A program or plan required by law, for example, Workers' Compensation.
 - c. Any type of automobile insurance coverage.
2. For Dependent Children, if both parents are covered by employer-sponsored group dental plans that cover their Children as Dependents:
 - a. The plan of the parent whose birthday is earliest in the year will be primary payor.

- b. If both parents have the same birthday (not taking into consideration the year), the plan that has covered the Dependent Child for the longest period of time will be the primary payor.
 - c. If the other plan covering a Dependent Child does not have a coordination of benefits provision based on birth dates, then the father's plan will be primary.
 3. If the parents of a Dependent Child are divorced or legally separated:
 - a. If a court decree places financial responsibility for health care expenses of the Child on either parent, that parent's plan will be the primary payor.
 - b. If there is no court decree placing financial responsibility for health care expenses of the Child on either parent:
 - i. The plan of the custodial parent will be the primary payor.
 - ii. If the custodial parent has remarried, the plan of the custodial parent will be primary, the plan of the stepparent will be secondary, and the plan of the non-custodial parent will determine its benefits.
 4. A plan covering a person as an employee will pay its benefits before a plan covering the same person as a Dependent.
 5. A plan covering a person as an active employee (or Dependent of an active employee) will pay its benefits before a plan covering a laid-off or retired employee.
 6. A plan covering a person as a laid off or retired employee will pay its benefits before a plan covering the same person as a Dependent of an active employee.
 7. If none of the above rules determine the order of payment, the plan which has covered the person for the longest period of time will be the primary payor.

If you have any questions about these rules, please call the Claim Administrator.

Right of Recovery

If, at any time, payments made under the Plan to or on behalf of a Participant or any of his covered Dependents exceed benefits actually payable, the Plan has the right to:

1. Recover the excess payments from any person or entity to or for whom the payments were made or from any organization or plan from which similar benefits remain payable; or
2. Offset payments due or that may become due under the Plan with respect to expenses incurred by the Participant or any of his covered Dependents to the extent of the overpayment.

Right to Examine

If you have filed a claim for benefits under the Plan, the Plan or the Claim Administrator may require that you have a Doctor of its choice examine you. In this case, the Plan will pay the full cost of the examination.

Assignment

Benefits provided under the Plan shall not be assignable without the consent of the Plan Administrator. The Participant may authorize the Plan Administrator to pay benefits directly to the Doctor providing dental treatment. Any such payments will discharge the Plan Administrator to the extent of payment made. Claim payments may not be attached or otherwise subject to seizure by any creditor of a Participant.

Payment for covered charges incurred by a Participant under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Participant, or his or her beneficiary, as required by an applicable state plan for medical assistance approved under Title XIX of the Social Security Act ("State Plan") pursuant to section 1912(a)(1)(A) (as in effect on the date of enactment of the Omnibus Budget Reconciliation Act of 1993).

The fact that an individual is eligible for or provided medical assistance under a State Plan shall not be taken into account in enrolling such individual as a Participant or beneficiary or in determining the entitlement or amount of any benefits due under the Plan.

To the extent that a State Plan has made payment for items that would be covered charges of a Participant under the Plan, payment of benefits hereunder shall be made in accordance with any State law that provides that the State has acquired the rights with respect to such Participant to such payment.

Misrepresentation

If an Employee or Dependent (or anyone acting on behalf of either) makes a false statement or withholds information, and as a result coverage is provided that would otherwise not have been, or a claim is paid that would otherwise not have been paid, the Plan has the right to:

1. Recover any amounts paid as a result of the misrepresentation;
2. Terminate coverage immediately; and
3. Recover its damages, including legal fees, from the Employee or from any other person responsible for misleading the Plan, and from the person for whom the benefits were provided.

Facility of Payment

The Plan will pay its benefits directly to your service provider if you sign a valid assignment of benefits. There is an "Authorization to Pay" on the Plan's claim form. This is where you should sign if you want the Plan to pay your service provider directly.

If the Claim Administrator determines that a valid release cannot be given for payment of Plan benefits, the Claim Administrator has the discretion to pay the individual who has assumed responsibility for your principal support and care.

If you should die before benefit payments have been made, the Claim Administrator may honor assignments you made before your death. Any payment made by the Claim Administrator in accordance with this provision shall fully satisfy its liability for payment.

Plan Modification and Amendment

The Plan Sponsor may modify or amend the Plan from time to time at their sole discretion, and any such amendments or modifications that affect Participants will be communicated to them.

Plan Termination

The Plan Sponsor may terminate the Plan at any time. If the Plan is terminated, your rights to benefits will be limited to claims incurred and due up to the date of termination.

No Effect on Employment

Nothing contained in this Plan shall be considered to guarantee a right to continued employment or to interfere with the right of a Participating Employer to discharge an Employee at any time.

ERISA Rights

As a Participant in the Plan, you have certain rights and protections under the Employee Retirement Income Security Act (ERISA). These are:

1. You may look at and read all Plan documents and papers, including insurance contracts, and copies of all reports and papers filed by the Plan with the U.S. Department of Labor. You may look at these papers in your Employer's office or at the Plan Administrator's office. There is no cost to you for looking at them.
2. You may get copies of all Plan documents and other Plan information from the Plan Administrator. You must ask for them by writing to the Plan Administrator. You will be charged for each page copied for you at the current commercial rate for copies at the time the copies are made.
3. You may get a copy of the Plan's annual report. Your Employer is required by law to give you a copy of the annual report if you ask for one.
4. The people who are responsible for the operation of the Plan and who, in fact, operate it are called "fiduciaries." By law they have a duty to operate the Plan carefully and to protect your interests. No one may fire you or discriminate against you in any way to stop you from getting benefits under the Plan or for taking advantage of the rights listed above.
5. If you have a claim and either the whole claim or part of it is not paid, the Claim Administrator must tell you, in writing, why it can't be paid. You may also ask the Plan Administrator and the Plan Sponsor to consider your claim again.

In order to protect these rights:

1. If you ask for Plan documents and papers and you do not get them within 30 days, you may file a lawsuit in federal court. The court could order the Plan Administrator to give you the materials and also to pay you as much as \$110 each day until you get them, unless the court finds that the Plan Administrator had good reasons for not sending them to you.
2. You can file a lawsuit in federal court if your claim is not paid, either in whole or in part, if after you have filed your claim you do not get a written response from the Claim Administrator explaining why the claim was not paid.
3. If the Plan fiduciaries do not use the Plan's money as they should, or if you are discriminated against for taking advantage of any of the rights listed in this section, you may get help from the U.S. Department of Labor or you can file a lawsuit in a federal court. The court will decide who will have to pay the legal fees and costs. If you file a lawsuit and the court finds that there is no reason to believe that you have a case, you may be ordered to pay the fees and costs. If the court finds that you do have a case, the people you sue may be ordered to pay the fees and costs.
4. If you have any questions about the Plan, call or write the Plan Administrator. If you have any questions about the rights described above, you can call or write either the Plan Administrator or the nearest office of the U.S. Labor-Management Services Administration (part of the Department of Labor).
5. The Plan has been established for Employees of the various Employers participating in the Butler Health Plan, and their Dependents. You can get a list of Participating Employers by writing to

HIPAA Privacy Standards

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Standards for Privacy of Individually Identifiable Health Information (the “Privacy Standards”) issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”), the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids for providing health insurance coverage or modifying, amending, or terminating the Plan.

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

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

In order that the Plan Sponsor may receive and use PHI for administration purposes, including payment and healthcare operations, the Plan Sponsor agrees to:

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

disclosure was made, or, if such return or destruction is not feasible, then limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

10. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - a. The following persons under control of the Plan Sponsor shall be given access to the PHI: Administrative Director, Associate Director, and Administrative Assistant of the Plan and Treasurers, Business Managers, and/or Human Resources Managers, and Benefit Representatives designated by Treasurers, Business Managers, and/or Human Resources Managers of the Participating Employers.
 - b. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
 - c. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Document relating to use and disclosure of PHI, the Plan's Privacy Officer shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs.

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

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

1. The Plan Document has been amended to incorporate the above provisions, and
2. The Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan and information about an individual's present or former enrollment in the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

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

Other Disclosures and Uses of PHI

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

HIPAA Security Standards

The Plan Sponsor will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Health Plan.
2. Ensure that the adequate separation required by the Privacy Rule is supported by reasonable and appropriate security measures.
3. Ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect the information.
4. Report to the Health Plan any security incident of which it becomes aware.

Summary of Material Modifications

Covered Persons shall be furnished summary descriptions of material modifications in the terms of this Plan and changes in the information required to be included in the summary plan description pertaining to this Plan not later than 210 days after the end of the Plan Year in which the change is adopted. However, in the case of any modification or change that is a material reduction in covered services or benefits provided under the Plan, Covered Persons will be furnished a summary of such modification or change not later than 60 days after the adoption of the modification or change, unless the Employer provides summaries of modifications or changes at regular intervals of not more than 90 days.

X. Miscellaneous Information

Name of the Plan: Butler Health Plan
Type of Benefit Plan: Dental

Plan Administrator: Butler Health Plan
Suite C
1910 Fairgrove Avenue
Hamilton, Ohio 45011
1-513-942-6262

Plan Sponsor: Butler Health Plan Board of Trustees
Butler Health Plan
Suite C
1910 Fairgrove Avenue
Hamilton, Ohio 45011

Dental Plan Number:
Employer ID Number: 31-1151537
Plan Administration: Contract Administered
Claim Administrator: Allied Benefit Systems, Inc.
P.O. Box 909786-60690
Chicago, IL 60690
1-800-288-2078

Agent for Service of Legal Process:

Administrative Director
Butler Health Plan
Suite C
1910 Fairgrove Avenue
Hamilton, Ohio 45011

* Note: Legal process may also be served on any of the plan trustees.

Plan Fiscal Year: January 1–December 31

Plan Currently Restated; January 1, 2008

XI. Definitions

As used in this Plan Document, and for purposes of Plan coverage, the following words and phrases have the meanings assigned to them, unless otherwise required by context:

1. *Abutment*: A tooth or root that retains or supports a fixed Bridge or a removable prosthesis.
2. *Accidental Injury*: An unintentional bodily Injury caused by an unexpected and undesirable set of events and is definite as to a time and a place. It does not include harm resulting from disease.
3. *Appliance*: A device used to provide function, therapeutic (healing) effect, space maintenance, or as an application of force to teeth to provide movement of growth changes as in Orthodontics.
 - a. Fixed: one that is attached to the teeth by cement or by adhesive materials and cannot be removed by the patient.
 - b. Removable: one that can be taken in and out of the mouth by the patient.
 - c. Prosthetic: used to provide replacement of missing tooth.
4. *Assignment of Benefits*: Your authorization to the Claim Administrator to pay Plan benefits directly to your service provider (for example, your Dentist or a orthodontist).
5. *Bite-wing*: A type of dental x-ray film that has a central tab or wing upon which the teeth close to hold the film in position. They are commonly called decay detecting x-rays.
6. *Bridge or Prosthetic Appliance*: Pontics or replacement teeth retained which Crowns or inlays cemented to the natural teeth, which are used as Abutments.
 - a. Fixed-removable: one which the Dentist can remove but the patient cannot.
 - b. Removable: a partial Denture retained by attachments, which permit removal of the Denture. Normally held by clasps.
7. *Co-Insurance*: The percentage of covered charges you must pay after you have met your annual Deductible. .
8. *Child/Children*:
 - a. Any natural Child of yours.
 - b. Any natural Child of your Spouse.
 - c. A Child legally adopted by you or your Spouse if the Child was placed for adoption before the Child's 18th birthday.
 - d. A Child who has been, and continues to be, legally placed for adoption with you or your Spouse before the Child's 18th birthday.
 - e. Any Child for whom you or your Spouse is legal guardian or has legal custody, if that child has the same principal place of residence as you and is a member of your household.
9. *Claims Administrator*: An entity authorized by the Plan to process claims for benefits under the Plan. The Claims Administrator is not an insurer of benefits or a fiduciary of the Plan; it has no discretionary authority with respect to eligibility or benefits; it is not responsible for Plan financing and does not guarantee Plan benefits.
10. *Cosmetic Treatment*: A treatment is "cosmetic" if it is designed to change the texture, shape or structure of any part of the body that is considered normal, allowing for age and ethnic origin, and is not Medically Necessary due to accident or Illness.
11. *Covered Person*: A person who is covered in this plan.
12. *Crown*: A natural Crown is the position of a tooth covered by enamel. An artificial Crown (cap) restores the anatomy, function and esthetics of a natural tooth.
13. *Deductible*: The amount the member pays each calendar year before the plan covers dental care costs or specified services.
14. *Dental Hygienist*: A person who has been trained to clean teeth and provide additional services and information on the prevention of oral disease.

15. *Dentist*: The term Dentist refers to an individual who is licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his license. For the purpose of this definition, a Physician will be considered to be a Dentist when he performs any of the dental services described in the Schedule of Benefits, and is operating within the scope of his license.
16. *Denture*: A device replacing missing teeth. The term usually refers to full or partial Denture but it actually means any substitute for missing natural teeth.
17. *Dependent*: Any person who qualifies for Plan coverage by virtue of meeting the requirements. (See—"Who Can Be Covered")
18. *Doctor or Physician*: A legally licensed M.D., D.O., chiropractor, optometrist, podiatrist, Dentist or oral surgeon who is practicing within the scope of his or her license.
19. *Electronic Protected Health Information*: This term has the same meaning as ascribed to it in 45 C.F.R. Part 160 and Part 164.
20. *Employer*: See the definition of "Participating Employer."
21. *Experimental or Investigational*: Any treatment, procedure, service, supply, device, or drug:
 - a. With respect to which there is no general consensus among knowledgeable Dentists that it is safe and effective; or
 - b. That is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnoses; or
 - c. That is subject to review and approval by the treating facility's institutional Review Board or other body serving a similar function; or
 - d. That is regarded as Experimental or Investigational; or
 - e. That does not meet the standards and guidelines established by the American Dental Association.
22. *Family*: The term Family means the Employee and his covered Dependents.
23. *Full-Time Student*: Any person who is enrolled as a student at an appropriately licensed or accredited educational institution for 12 credit hours per grading period or on a full-time basis as defined by the institution (except for normal school breaks within an academic year or between two consecutive academic years). Note that a student may elect to continue full-time studies during an extended normal break period (i.e., summer vacation) and substitute either a standard academic quarter or academic semester as a replacement break period if such break is completed within twelve months of the beginning of the next year's summer vacation.
24. *Illness*: A physical or mental disease or infirmity that interferes with normal bodily functions. It includes pregnancy and pregnancy-related conditions.
25. *Injury*: Bodily damage caused by sudden, accidental, external means.
26. *Jaw Joint Treatments*: Treatments of temporomandibular joint syndrome (TMJ) and craniomandibular disorders or other conditions of the joint linking the jawbone and skull and the complex of muscles, nerves, and other tissues related to that joint.
27. *Lifetime Benefit Maximum*: The total amount of benefits payable by the plan for an enrollee during his or her lifetime.
28. *Maximum Benefit*: The plan will pay a maximum amount for a service for a specified period or the entire time that you are in the plan. When the Maximum Benefit is paid, the plan will pay no more benefit for the specified service.
29. *Medically Necessary*: Services or supplies provided by a covered provider that are required for treatment of Illness, Injury, diseased condition, or impairment and are:
 - a. Consistent with the patient's diagnosis or symptoms;
 - b. Appropriate treatment, according to generally accepted standards of medical or dental practice;

- c. Not provided mainly as a convenience to the patient, provider or any other person;
- d. Not Experimental or Investigational; and
- e. Not excessive in scope, duration or intensity needed to provide safe, adequate, and appropriate treatment. Any services or supplies provided at a particular facility will not be considered Medically Necessary if the patient's symptoms or condition indicate that it would be safe to provide the service or supply in a less comprehensive setting.

The fact that any particular provider may prescribe, order, recommend, or approve a service, supply or level of care does not, of itself, make that treatment Medically Necessary or make the charge a covered charge

- 30. *Named Fiduciary*: The person or entity who has the complete authority to control and manage the operation and administration of the Plan. The Named Fiduciary for the Plan is the Plan Sponsor. In exercising its fiduciary responsibilities, the Plan Sponsor shall have the discretionary authority to determine eligibility for benefits, review denied claims for benefits, interpret Plan provisions, construe disputed Plan terms and select managed care options. The Plan Sponsor shall be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously. Any other individual or entity exercising any discretionary authority with respect to the Plan shall also be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously
- 31. *Participant*: Any individual entitled to participate in the Plan, under the requirements set forth in this Plan Document, either as an eligible Employee of a Participating Employer or as an eligible Dependent.
- 32. *Participating Employer or Employer*: Any employer participating under the terms and provisions of the Butler Health Plan.
- 33. *Plan*: Butler Health Plan
- 34. *Pontic*: The part of the fixed Bridge, which is suspended between the Abutments and which replaces missing tooth or teeth.
- 35. *Premium*: The monthly cost you pay to BHP for your coverage. Your Employer pays a portion of this cost. You pay a portion of the cost through payroll deduction.
- 36. *Privacy Rule*: The rules set forth in 45 CFR Part 160 and Part 164, Subparts C and E.
- 37. *Usual and Customary Charge (U/C)*: The amount usually charged by Doctors or suppliers of services or supplies so long as it is not more than the general level of charges made by others providing the same services or supplies in the geographic area to treat an Illness or Injury of comparable severity. "Area" means a county or such other area as is necessary to obtain a representative cross-section of the charges.
- 38. *You, Your, Yours, Yourself*: These and similar terms refer, as appropriate to context, to any person covered as a Participant under the Plan. However, in the section "Who Can Be Covered" these terms refer only to the Employee who is either covered or eligible for coverage.