

**Case Western Reserve University  
Summary Plan Description for  
The DenteMax™ Dental Plan  
January 2002**

**How to Use Your Plan Booklet**

This Booklet gives you the information you need to understand the dental benefits provided through Case Western Reserve University. Please read this Booklet carefully and, if you have any questions regarding your dental care benefits, contact Benefits Administration (216-368-6781) or:

North American Benefits Network, Inc.  
PO Box 94928  
Cleveland, Ohio 44101-4928  
440-356-8212  
Toll Free: 1-877-801-1500

You should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test, or any other aspect of Plan benefits or requirements.

**Schedule Of Benefits**

A Schedule of Benefits is provided on pages 3 & 4 of this Booklet. The Schedule of Benefits gives you information about dental procedures covered by the Plan and about the limits of your coverage.

**Definitions**

This section defines terms that have special meanings in the Plan. If a word or phrase starts with a capital letter, it has a special meaning and you will find its meaning set forth in this section.

**Eligibility, Funding, Effective Date And Termination**

This section explains when and how you and your Eligible Dependents become eligible for coverage under the Plan, funding of the Plan and when coverage takes effect and terminates.

**General Description of Coverage**

This section tells you things such as:

- Coverage For Services Of A Panel Dentist
- Coverage For Services Of A Non-Panel Dentist
- Coverage For Services In The University Dental Clinic
- Maximum Benefits
- Predetermination of Benefits
- Benefits After Termination
- Payment of Benefits

**Covered Services**

This section explains each type of dental benefit in your coverage. It also tells you what treatments, services and supplies are Covered Services. The Schedule of Benefits tells you the amount of your benefits.

**Limitations**

This section details those dental services, which are limited under the Plan.

**Exclusions**

This section details those dental services, which are not covered under the Plan.

**General Provisions**

This section provides information that should prove helpful on topics such as:

How To Apply For Benefits

Appeals Procedure

COBRA Continuation Options (Who May Continue Coverage)

Certain Plan Participants Rights Under ERISA (What You Have the Right to Expect)

**Case Western Reserve University  
DenteMax™ Plan  
Schedule of Benefits**

**Benefit Period:** Calendar Year  
**Calendar Year Maximum:** \$1,500 per Covered Person per year

**Benefits For Services Rendered**  
(All Payments Subject To Deductible)

	<b><u>DenteMax™ Panel</u></b>	<b><u>Non-Panel</u></b>
<b>Deductible:</b>	None	\$50 Individual \$100 for any multiple designation (i.e. Family)
<b><u>Type I Expenses:</u></b>	<b>Preventive Care</b>	
<b>Oral Examination</b>	100%	70% R & C*
<b>Dental X-Rays</b>		
<b>Bitewing</b>	100% - 2 per Calendar Year	70% R & C - 2 per Calendar Year
<b>Full Mouth</b>	100% - 1 every 3 Calendar Years	70% R & C - 1 every 3 Calendar Years
<b>Prophylaxis (cleaning)</b>	100%	70% R & C
<b>Occlusal Sealants</b> <i>(for children under age 13)</i>	100%	70% R & C
<b><u>Type II Expenses:</u></b>	<b>Basic Care</b>	
Restorative	80%	60% R & C
Endodontics	80%	60% R & C
Oral Surgery	80%	60% R & C
Periodontics	80%	60% R & C
<b><u>Type III Expenses:</u></b>	<b>Major Care</b>	
Crowns	60%	40% R & C
Bridges	60%	40% R & C
Dentures	60%	40% R & C

\*R & C designates Reasonable & Customary Fee levels.

**Benefits For Services Rendered (cont.)**

(All Payments Subject To Deductible)

	<b><u>DenteMax™ Panel</u></b>	<b><u>Non-Panel</u></b>
<b><u>Type IV Expenses:</u></b>	<b>Orthodontia</b>	
<b>Orthodontia</b>	50%	35% R & C*
<i>For children under age 19 only – after one year of plan participation</i>		
<b>Lifetime Orthodontia Benefit</b>	\$1,250	\$800

\*R & C designates Reasonable & Customary Fee levels.

## DEFINITIONS

**Acrylic** - a resin used in dentistry for Restorations, fixed and removable prosthetic appliances.

**Amalgam** - a material used in Restoration such as filling cavities.

**Apex** - the end of the tooth root.

**Bitewing** - Dental x-rays showing approximately the Coronal halves of the Maxillary and Mandibular teeth on the same film.

**Booklet** - this document which explains and details the benefits provided under Case Western Reserve University DenteMax Dental Plan and which represents a Summary Plan Description in accordance with applicable provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

**Calculus** - (tartar) - a hard mineralized deposit attached to the teeth.

**Calendar Year** - a time period that runs from January 1 through December 31.

**Caries** - a progressive destruction of the teeth from bacterially produced acids on the tooth surfaces. A localized progressive disintegration of tooth structures. An irreversible disease.

**Cavity** - a carious lesion or hole in the tooth.

**Claims Administrator** - North American Benefits Network provides claims administration and processing for the Plan under an "Administrative Services Only" arrangement with Case Western Reserve University.

**Coinsurance** - a specified percentage of the applicable charge Incurred for which you are responsible.

**Composite** - a plastic Restorative material.

**Coronal** - pertaining to the Crown.

**Covered Person** - the Eligible Employee and, if family coverage is in force, the Eligible Employee's Dependents.

**Covered Service** - treatments, services and supplies described in this Booklet for which the Plan will provide benefits.

**Crown** - the portion of a tooth covered by enamel (the topmost part).

**Dental Hygienist** - A person trained and licensed to practice the art of dental Prophylaxis under the direction of a licensed Dentist.

**Dentist** - a licensed Physician whose profession is to treat disease and injuries of the teeth and oral Cavity, and to construct and insert Restorations.

**Diagnostic** - oral examinations and x-rays used to determine the presence or absence of dental disease.

**Effective Date** - the date on which your coverage under this Plan begins.

**Eligible Dependent** - a Covered Person other than the Eligible Employee as described in the eligibility section.

**Eligible Employee** - all regular full-time and part-time employees of Case Western Reserve University who are also eligible to participate in the Case Western Reserve University Section 125 cafeteria plan, Benelect.

**Endodontic** - the diagnosis and treatment of diseases of the tooth Pulp, Root Canal and the Periapical area.

**Fluoride** - a solution which is applied topically to the teeth for the purpose of preventing dental Caries.

**Illness** - physical Illness.

**Incurred Expense** - an expense is Incurred when the service is performed, except that it is deemed to be Incurred

- when the final impression is taken, in the case of dentures or fixed bridgework;
- when preparation of the tooth is begun, in the case of Crown work;
- when the Pulp Chamber is opened and canals explored in the case of Root Canal work;
- when work on the tooth is begun, in the case of Root Canal therapy.

**Injury** - a bodily Injury sustained accidentally by external means. All Injuries received by an individual in any one accident will be considered one Injury.

**Legal Guardian** – a person recognized by a court of law as having the duty of taking care of the person of and managing the property and rights of a minor child.

**Mandible** - the lower jaw.

**Maxilla** - the bone forming the upper jaw.

**Medical Services** - those professional services whenever performed by Physicians, including Reasonable and Customary Medical, surgical, evaluative and Preventive services, and which are performed, prescribed, ordered, authorized or directed by Physicians.

**Medically Necessary (or Medical Necessity)** - a treatment, service or supply that is required to diagnose or treat a condition, Injury or Illness and which is determined to be:

- (a) appropriate with regard to generally recognized standards of good medical practice;
  - (b) not primarily for the convenience of a Covered Person or a health care Provider;
- and

(c) the most appropriate supply, treatment or level of service which can be safely provided to a Covered Person.

When applied to the care which you receive as an inpatient, Medically Necessary means that your medical symptoms or condition is such that the services cannot be safely or adequately provided to you as an outpatient.

If your health care Provider fails to supply sufficient information with respect to your physical or mental condition and the diagnosis relating to your condition such that the Claims Administrator is unable to determine whether the treatments, services or supplies are Medically Necessary, then any charges for such treatments, services or supplies will not be paid under the Plan.

**Non-Panel Dentist** - a Dentist, as defined under "Dentist" above, who is not under contract with DenteMax at the time services are rendered.

**Oral Examination** - the act of examination or investigation of the oral Cavity, using visual, x-ray, digital, and other means for Diagnostic purposes.

**Oral Surgery** - simple extractions, including surgical extractions, and certain other outpatient surgical procedures not covered by your medical plan, including pre- and post-operative care.

**Orthodontics** - procedures performed by a licensed Dentist involving the use of appliance therapy and surgical therapy to correct malocclusion.

**Panel Dentist** - a Dentist, as defined under "Dentist" above, who is under contract with DenteMax at the time services are rendered.

**Periapical** - tissues surrounding the end of a tooth root.

**Periodontics** - examination, diagnosis and treatment of diseases affecting tissues supporting the teeth.

**Physician** - an individual who is licensed to practice medicine, osteopathy, podiatry or dentistry, provided that the person is legally licensed to provide the Covered Services which are rendered to Covered Persons.

**Plan** - the DenteMax Dental Plan covering Eligible Employees of Case Western Reserve University and their Eligible Dependents. Case Western Reserve University reserves the right to modify or discontinue the Plan at any time.

**Plan Participant** - is any employee or dependent who is covered under this Plan.

**Practitioner** - a licensed Dental Hygienist legally licensed to provide the Covered Services which are rendered to Covered Persons.

**Preventative** - serving to stop the occurrence of dental disease.

**Prophylaxis** - prevention of disease by removal of Calculus, stains and other extraneous materials from the teeth. The cleaning of the teeth by a Dentist or Dental Hygienist.

**Prosthodontics** - branch of dentistry concerned with replacement of natural teeth including the construction and repair of fixed bridges, partial and complete dentures.

**Provider** - a licensed hospital, Physician, Dentist, medical facility, or Practitioner legally licensed or permitted by law to provide Covered Services.

**Pulp** - connective tissue found in the Pulp Chamber and canals. It is made up of arteries, veins, nerves and lymph tissue.

**Pulp Chamber** - the space in the Coronal portion of the tooth occupied by the Pulp.

**Reasonable and Customary Charge** - the criteria used to determine the maximum amount that the Plan will pay for a Covered Service. Determination as to whether a charge is Reasonable and Customary will be Final. The Reasonable and Customary Charge is based upon the following criteria:

**Reasonable Charge** - a charge which meets the customary criterion or which is determined to be reasonable when unusual circumstances or medical complications requiring additional time, skill and experience are taken into consideration.

**Customary Charge** - the charge which does not exceed the general level of charges being made by others of similar standing in the locality where the charge is Incurred, when furnishing like or comparable treatments, services or supplies to individuals of the same sex and of comparable age, for a similar Injury or Illness. The term "locality" means a metropolitan area, a county or a larger area, if necessary to establish a representative cross section of persons providing the type of treatment, service or supply.

The Reasonable and Customary Charge is always the lower of the amount determined or the Provider's actual charge.

**Restorative** - the practice of restoring teeth to normal function. Restoration includes:

- (a) reconstruction;
- (b) the replacement of missing parts;
- (c) the correction of accidental Injury or removal of diseased parts and replacement with fillings, inlays, onlays or Crowns.

**Restorative - (Basic)** - removal of dental decay, fillings and similar operations.

**Restorative - (Major)** - gold foil, gold inlays, porcelain, Crowns, bridgework, partial and complete dentures.

**Root Canal** - the space within the root of a tooth, containing nerves and blood vessels. They connect the Pulp Chamber with the Apex of the root.

**Scaling** - to remove Calculus (tartar) and stains from the teeth with a scaler and other special instruments.

**Sealant** - material used when performing Root Canal therapy.

**Silicate** - a material used to seal pits and fissures in children's teeth.

**University** - "the University" refers to Case Western Reserve University in all instances.

## **ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS**

### **Who Is Eligible**

All regular full-time and part-time staff and faculty who are eligible to participate in the Case Western Reserve University Section 125 Cafeteria Plan, Benelect, are also eligible for dental coverage under the Plan.

### **Eligible Dependents**

If you enroll for family coverage, your spouse or spouse equivalent and Eligible Dependent children are also eligible for Plan benefits. Eligible Dependent children include only:

- (a) Your unmarried children from birth to the limiting age of 19. Such children include: (1) your natural children, (2) a legally adopted child or child placed with you in anticipation of adoption, (3) a stepchild residing in your household, or (4) any child permanently residing in your household of which you are the sole support, provided you are related to the child by blood or marriage and are the child's Legal Guardian.

The phrase "child placed with you in anticipation of adoption" refers to a child whom you intend to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

- (b) Your unmarried children after attainment of age 19 and up to, but not including, the limiting age of 23 who are full-time students.

Full-time student coverage continues only between semesters/quarters if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the calendar month in which the last attended school term ended.

- (c) Your unmarried children after attainment of age 19 while incapable of self-support because of a disabling illness or injury that commenced prior to attainment of age 19. Such children must otherwise meet the eligibility requirements and must be principally supported by you.

At any time, the Plan may require proof that a spouse or a child qualifies or continues to qualify as an Eligible Dependent as defined by this Plan. Special certification will be required to substantiate:

- Legal Guardianship
- Full-time student status
- Disabled dependent eligibility
- Medical responsibility for children of divorced parents

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to dependent coverage under this Plan. A participant of the Plan may obtain, without charge, a copy of the procedures

governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

## **Funding**

### **Cost of the Plan.**

Case Western Reserve University shares the cost of employee and dependent coverage under this Plan with the covered employees. The enrollment application for coverage includes a payroll deduction authorization. This authorization must be signed when completing the enrollment application.

The level of any employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of employee contributions.

## **Enrollment**

You are eligible to enroll in the Plan upon employment - provided you are not covered under any other Dental Care Plan offered by another company. Please refer to Coordination of Benefits provisions in this Booklet on page 29 for further details.

**Enrollment Requirements.** You must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. You may enroll for either “single”, “employee + child(ren)”, “employee + spouse”, “employee + spouse equivalent”, or “family” coverage.

Please note: If you drop dental coverage during the open enrollment period, you will not be eligible to select dental coverage again for two years.

## **Timely or Late Enrollment**

- (1) Timely Enrollment** - The enrollment will be “timely” if the completed form is received by the Plan Administrator no later than 30 days after the employee or dependent becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two employees (the mother and father of the child(ren)) are covered under the Plan and the employee who is covering the dependent child(ren) terminates coverage, the dependent coverage may be continued by the other covered employee with no Waiting Period as long as coverage has been continuous.

- (2) Late Enrollment** - An enrollment is “late” if it is not made on a “timely basis” or during a Special Enrollment Period. Late Enrollees and their dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

Coverage begins on the first of the month after enrollment which would be January 1<sup>st</sup> for anyone enrolling during open enrollment.

### **Special Enrollment Periods**

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. The time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period.

- (1) Individuals losing other coverage.** An employee or dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:
- (a)** The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
  - (b)** If required by the Plan Administrator, the employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
  - (c)** The coverage of the employee or dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated.
  - (d)** The employee or dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above.

If the employee or dependent lost the other coverage as a result of the individual's failure to pay premiums or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

**(2) Dependent beneficiaries. If:**

- (a)** the employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b)** a person becomes a dependent of the employee through marriage, birth, adoption or placement for adoption

then the dependent (and if not otherwise enrolled, the employee) may be enrolled under this Plan as a covered dependent of the covered employee. In the case of the birth or adoption of a child, the spouse of the covered employee may be enrolled as a dependent of the covered employee if the spouse is otherwise eligible for coverage.

The dependent Special Enrollment Period must be a period of not less than 31 days and must begin on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the dependents enrolled in the Special Enrollment Period will become effective:

- (a) in the case of marriage, as of the date of marriage;
- (b) in the case of a dependent's birth, as of the date of birth; or
- (c) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

### **Keeping Your Coverage Up-To-Date**

You should notify your Benefits Representative whenever your personal status or that of your dependents changes in such a way as to affect your coverage. Typical changes of this sort occur when:

- you marry;
- you have a child;
- a covered dependent becomes ineligible;
- you are no longer married.

Coverage for newborn babies and new spouses becomes effective on the date of birth or marriage provided you change your contract to family coverage and add the new dependent's name within **30 days of the event**. This change can be made by completing an enrollment application. A newborn child of a covered employee who has dependent coverage is not automatically enrolled in this Plan.

### **Effective Date Of Coverage**

**Effective Date of Employee Coverage.** Coverage would become effective on the first day of the calendar month following your date of hire, unless you are hired on the first business day of the month in which case coverage is effective on your date of hire.

**Effective Date of Dependent Coverage.** A dependent's coverage will take effect on the day that the dependent Eligibility Requirements are met; the employee is covered under the Plan; and all Enrollment Requirements are met. Newborn children enrolled for coverage on a timely basis will be effective from the moment of birth.

### **Termination of Coverage**

**When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.**

**When Employee Coverage Terminates.** Employee coverage will terminate at midnight on the earliest of these dates (except in certain circumstances, a covered employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Option):

- (1) The date the Plan is terminated.
- (2) The last day of the calendar month in which the covered employee ceases to be in one of the Eligible Classes. This includes death or termination of employment of the covered employee. (See the COBRA Continuation Option.)
- (3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

**Continuation During Family and Medical Leave.** This Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the employee and his or her covered dependents if the employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the employee and/or his or her dependents when Plan coverage terminated.

**Rehiring a Terminated Employee.** A terminated employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, with the exception of an employee returning to work directly from COBRA coverage. This employee does not have to satisfy the employment Waiting Period.

**Employees on Military Leave.** Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to employees and their dependents covered under the Plan before leaving for military service.

- (1) The maximum period of coverage of a person and the person's dependents under such an election shall be the lesser of:
  - (a) The 18 month period beginning on the date on which the person's absence begins; or
  - (b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.
- (2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

**When Dependent Coverage Terminates.** Your dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Option):

- (1) The date the Plan is terminated.

- (2) On the last day of the calendar month in which the employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Option.)
- (3) The date dependent coverage is terminated under the Plan.
- (4) On the last day of the calendar month in which he or she ceases to be a dependent as defined by the Plan. (See the COBRA Continuation Option.)
- (5) In the event of divorce or dissolution, the dependent spouse's coverage terminates at the end of the month in which the divorce or dissolution occurs. (See the COBRA Continuation Option.)
- (6) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

## GENERAL DESCRIPTION OF COVERAGE

This section provides several general provisions which explain proper usage of your Plan in order to receive the payment detailed in the Schedule of Benefits.

### Coverage For Services Of A Panel Dentist

The Plan will pay for Covered Services based upon the charges by a Panel Provider in accordance with the percentage listed in the Schedule of Benefits. The percentage not paid by the Plan is the Coinsurance amount for which you are totally responsible. You should also note that there are treatments, services, and supplies listed under Exclusions for which you will receive no benefits at all.

### Coverage For Services Of A Non-Panel Dentist

When you receive Covered Services from a Non-Panel Dentist **upon the referral of a Panel Dentist or in an emergency situation for the alleviation of pain where you cannot receive the services from a Panel Dentist**, the charges for those services will be covered as if the services had been provided by a Panel Dentist.

If you receive services from a Non-Panel Dentist by your own choice, the charges for those services will be covered at a reduced percentage of coverage provided for a Panel Dentist. However, reimbursement in these cases is further limited to the applicable percentage of the amount charged not exceeding the Reasonable and Customary (R&C) Charge for these services. Thus, Preventive services would be covered at 70% of R&C, basic services would be covered at 60% of R&C and major services would be covered at 40% of R&C.

For services rendered by Non-Panel Dentists (excluding referrals by a Panel Dentist), only that part of a charge which is REASONABLE is covered. The Reasonable Charge for a service or supply is the lesser of:

- the charge usually made for it by the Provider who furnishes it, and
- the prevailing charge made for it in the same geographic area, by those of similar professional standing.

If the Reasonable and Customary Charge for a service or supply cannot be determined because of the unusual nature of the service or supply, to what extent the charge is reasonable will be determined by taking into account the complexity involved, degree of professional skill required, and other pertinent factors.

### Coverage For Services In The University Dental clinic

Services rendered in the University Dental clinic by students working under the supervision of a licensed Dentist are reimbursable at panel levels. Refer to the Schedule of Benefits for coverage information.

### Maximum Benefits

All Covered Services are subject to a Calendar Year maximum. The maximum is the total amount payable under the Plan per Covered Person during a particular Calendar Year. Please refer to the Schedule of Benefits to determine the appropriate Calendar Year maximum.

### **Predetermination of Benefits**

Before beginning a course of treatment for which Dentists' charges are expected to exceed \$200, a description of the proposed course of treatment and charges to be made should be filed in acceptable form with North American Benefits Network. Case Western Reserve University's Claims Administrator North American will then predetermine the estimated benefits payable for covered dental expenses expected to be Incurred, and advise you and your Dentist before treatment begins.

Emergency treatments, Oral Examinations including Prophylaxis, and dental x-rays are considered part of a course of treatment, but these services may be rendered before predetermination is made.

### **Alternate Treatment**

If alternate services or supplies may be used to treat a dental condition, covered dental expenses will be limited to the services and supplies which are customarily employed nationwide to treat the disease or Injury and which are recognized by the profession to be appropriate methods of treatment in accordance with broadly accepted national standards of dental practice, taking into account the family member's total current oral condition. See the Limitations section of this benefit for some examples of how this provision operates.

### **Benefits After Termination**

Benefits are not payable after a Covered Person's coverage terminates. However, if a Covered Person's coverage terminates (for reasons other than the termination of the Case Western Reserve University DenteMax Dental Plan itself), benefits will be payable with respect to:

- Root Canal therapy where the work is begun prior to the date of termination.
- Dentures, fixed bridgework, or Crowns ordered prior to the date of termination.

"Ordered" means that preliminary planning and preparation has been completed. For a denture, this means that impressions have been taken from which it will be prepared. For the other items noted, this means that the teeth which will serve as retainers or support, or which are being restored, have been fully prepared to receive the item and impressions have been taken from which it will be prepared.

In no event shall such benefits be payable for Covered Services rendered more than 60 days after the date a person's coverage terminates.

### **Payment of Benefits**

The Plan will make payment directly to the Provider if you utilize the services of a Panel Dentist. Payment for services of a Non-Panel Dentist will be made to the Provider if

benefits are assigned or directed to you, if benefits are not assigned, or the claim is accompanied by a paid receipt from the Provider.

If you are also a participant in a Healthcare Spending Account, charges submitted to the DenteMax Plan for deductibles and Coinsurance can be processed automatically through your Healthcare Spending Account. This eliminates the need to file claims for these types of expenses twice.

You will be given the option after the open enrollment period, whether or not you wish your Healthcare Spending Account dollars to be used for the automatic processing of DenteMax deductibles and Coinsurance amounts.

## COVERED EXPENSES

This section describes the Covered Services available to you under the Plan when rendered by a DenteMax Provider.

### **Type I Expenses:**

Routine Oral Examinations but not more than twice in any Calendar Year period.

Topical application of Fluoride.

Routine Scaling and polishing of teeth, but not more than twice in any Calendar Year period.

Full mouth x-rays but not more than once in any 3 Calendar Year period.

Supplementary Bitewing x-rays but not more than once in any Calendar Year period.

X-rays as required in connection with the diagnosis of a specific condition requiring treatment except x-rays provided in connection with Orthodontic Diagnostic procedures and treatment.

Space maintainers that replace teeth lost prematurely due to disease for dependent children under 19 years of age.

Initial application of occlusal sealants for dependent children under age 13.

Emergency palliative treatment.

### **Type II Expenses:**

Simple extractions.

Amalgam, Silicate, Acrylic, porcelain, and Composite filling Restorations to restore diseased or fractured teeth.

Treatment for accidental Injury to natural teeth.

Injection of antibiotic drugs by the attending Dentist.

Oral Surgery.

Treatment of diseases of the gums and other tissues of the mouth including periodontal Prophylaxis (cleaning) which may be performed three times in any period of 12 consecutive months.

Endodontic treatment (those procedures usually employed for prevention and treatment of diseases of the dental Pulp and the area surrounding the tip of the tooth root), including Root Canal therapy.

Repair or recementing of Crowns, inlays, onlays, bridgework, or dentures; or relining or rebasing of dentures more than six months after the installation of an initial or

replacement denture, but not more than one relining or rebasing in any period of 36 consecutive months.

Administration of anesthetics when Medically Necessary, except local infiltration anesthetic provided either in or out of a hospital, and administered in connection with Oral or dental Surgery. Benefits are not provided for substances or agents which are administered to produce a state of sedation or relaxation or to minimize fear or reduce or eliminate pain while the patient is conscious, unless the patient is handicapped by cerebral palsy, mental retardation, or spastic disorders.

### **Type III Expenses:**

Initial installation of fixed bridgework to replace missing natural teeth (including Inlays and Crowns as abutments except periodontal splinting).

Initial installation of partial or full removable dentures to replace missing natural teeth and adjacent structures (including precision attachments which can be justified as functionally necessary with study models and radiographs). Includes adjustments for the six-month period following installation.

Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:

- (a) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or
- (b) the existing denture or bridgework *cannot be* made serviceable and at least five years have elapsed prior to its replacement; or
- (c) the existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

**Note: Normally, dentures will be replaced by dentures, but if a professionally adequate result can be achieved only with bridgework, such bridgework will be a covered dental expense.**

Inlay, onlays, gold fillings, or Crown Restorations to restore diseased teeth but only when the tooth, as a result of Caries, cannot be restored with an Amalgam, Silicate, Acrylic, porcelain, or Composite filling Restoration.

### **Type IV Expenses:**

Orthodontic Diagnostic procedures (including examinations and x-rays) and treatment consisting of appliance therapy and surgical therapy to correct malocclusion for dependent children under 19 years of age.

**Note: To be eligible for Orthodontic expenses, you must be a participant in the DenteMax Dental Plan for a period of 12 consecutive months prior to the period for which expenses are payable.**

## LIMITATIONS

The following limitations apply:

### Restorative:

- **Gold or Porcelain Restorations and Crowns**  
If a tooth can be restored with a material such as Amalgam, payment of the applicable percentage for that procedure will be made toward the charge for another type of Restoration selected by you and your Dentist. The balance of the treatment charge remains your responsibility.
- **Partial Dentures**  
If a cast chrome or Acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the cost of such procedure will be made toward a more elaborate or precision appliance that you and your Dentist may choose to use, and the balance of the cost remains your responsibility.
- **Complete Dentures**  
If, in the provision of complete denture services, you and your Dentist decide on personalized Restorations or specialized techniques as opposed to standard procedures, payment of the applicable percentage of the cost of the standard denture services will be made toward such treatment, and the balance of the cost remains your responsibility.
- **Replacement of Existing Dentures**  
Replacement of an existing denture will be a covered dental expense only if the existing denture is unserviceable and cannot be made serviceable. Payment based on the applicable percentage will be made toward the cost of services which are necessary to render such appliances serviceable. Replacement of Prosthodontic appliances will be a covered dental expense only if at least five years have elapsed since the date of the initial installation of that appliance under this Plan.
- **Reconstruction**  
Payment based on the applicable percentage will be made toward the cost of procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or Restorations necessary to alter vertical dimension in restoring occlusion are considered optional and their cost is your responsibility.

## EXCLUSIONS

The following exclusions under the CWRU Dentemax Dental Plan apply:

- Services other than those specifically covered herein.
- Charges for any dental services and supplies which are covered in whole or in part under any other plan or benefits provided by the employer.
- Charges for treatment by other than a Dentist or a Graduate Student Dentist of the Case Western Reserve University Dental Clinic, except that Scaling or cleaning of teeth and topical application of Fluoride may be performed by a licensed Dental Hygienist if the treatment is rendered under the supervision and guidance of the Dentist and billed by the Dentist.
- Charges for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.
- Services rendered or provided prior to the Effective Date of coverage.
- Services Incurred after coverage termination.
- Charges for prosthetic devices including bridges, Crowns, inlays and onlays, and the fitting thereof that were ordered while the individual was not covered for dental expense benefits, or that were ordered while the individual was covered for dental expense benefits but are finally installed or delivered to such individual more than sixty days after termination of coverage.
- Charges for the replacement of a lost, missing or stolen prosthetic device.
- Charges for any duplicate prosthetic device or any other duplicate appliance.
- Charges for oral hygiene, dietary instructions, plaque control and other educational programs.
- Dentures, Crown, inlays, onlays, bridgework and other appliances or services intended to increase vertical dimension or restore occlusion.
- Treatment of temporomandibular joint (TMJ) syndrome.
- Charges for drugs or medications.
- Services for which the individual is not required to make payment or for which no charge would be made in the absence of coverage under the DenteMax Dental Plan.
- Services for which payment or reimbursement is received by or for the account of the individual as a result of legal action or settlement.
- Charges for veneers or similar properties of Crowns and pontics placed on or replacing teeth, other than the ten upper and lower anterior teeth.

- Charges for services or supplies furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.
- Charges for services or supplies for which benefits are furnished, paid for, or for which benefits are provided or required by any law of a government. (This does not include a plan established by a government for its own employees or their dependents).
- Treatments which are for an Illness or Injury occurring in the course of employment if whole or partial benefits or compensation are available under the Workers' Compensation Act or any similar law. This applies whether or not the Covered Person claims such compensation or recovers losses from a third party.
- Treatment for any Injury resulting from or occurring during your commission of a felony.
- Treatment for Illness or Injury that occurs as a result of any act of war.
- Charges for services or supplies which are not necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending Dentist.
- Charges for services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature.
- Charges for services provided in an inpatient hospital setting. (These expenses may be considered for coverage under your medical plan.)

## NON-DUPLICATION PROVISION

The dental care benefits otherwise provided under the Plan are subject to the following non-duplication provisions:

- (1)** The dental care benefits of the Plan will not be available to the extent they are provided to you under any other group plan if the other plan:
  - (a)** does not include a Coordination of Benefits or Nonduplication Provision, or
  - (b)** includes a Coordination of Benefits or Non-duplication Provision and is the primary plan as compared to this Plan.
- (2)** In determining whether this Plan or another group plan is primary, the order of benefits liability will be determined by using the first of the following rules that applies:
  - (a)** A plan that does not coordinate with other plans is always the primary coverage.
  - (b)** The plan that covers a person as an employee, member, insured or subscriber, other than as a dependent, is the primary coverage.
  - (c)** When more than one plan covers the child as a dependent of different parents who are not divorced or separated, the primary coverage is the plan of the parent whose birthday falls earlier in the year. If both parents have the same birthday, the plan that covered the parent longer is the primary coverage. This is the birthday rule. If the other plan is not subject to regulation under the new law but, instead, has a rule based on the gender of the parent, the rule of the other plan will determine the order of benefits liability.
  - (d)** If more than one dental plan covers the same child as a dependent of divorced or separated parents, benefits will be determined in the following order, provided the specific terms of a court decree do not state otherwise:
    - (i)** The plan of the parent with custody is primary.
    - (ii)** The plan of the spouse of the parent with custody is primary.
    - (iii)** The plan of the parent without custody of the child is primary.If the specific terms of a court decree state that one parent is responsible for the dental care expenses of the child, then the plan of that parent is primary.
  - (e)** The plan that covers a person as an employee who is neither laid off nor retired, or that employee's dependent, is the primary coverage. The secondary plan is the plan that covers the person as a laid off or retired employee, or that employee's dependent.

- (f) If none of the above rules determines the order of benefits liability, the plan that covered an employee, member, insured or subscriber longer is the primary coverage.

**Note: In any case where this Plan is determined to be secondary, benefits otherwise payable under the Plan are reduced by benefits payable by the other plan, except dental benefits calculated by reducing covered dental expenses under the Plan by the other plan payment.**

As used herein, "group plan" means: (1) any plan covering individuals as members of a group and providing dental care benefits through group insurance or a group prepayment arrangement; or (2) any plan covering individuals as employees of an employer and providing such benefits or services, whether on an uninsured basis.

If it is determined that benefits under this Plan should have been reduced because of benefits provided under another group plan, the University will have the right to recover from the covered employee, any payment already made which is in excess of the University's liability. Similarly, whenever benefits which are payable under the Plan have been paid under another group plan, the University may make reimbursement directly to the insurance company or other organization paying benefits under the other plan.

For the purpose of this provision, North American Benefits Network, as the Claims Administrator for the University, may without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person, any information which may be necessary regarding coverage, expenses and benefits.

Any person claiming benefits under the Plan shall provide the University's Claims Administrator, North American Benefits Network, such information as may be necessary for the purpose of administering this provision.

## NO FAULT PROVISION

The benefits otherwise payable under the Plan will be offset by similar benefits payable for dental expenses or which would be payable upon timely and proper submission of claim (unless good and sufficient reason is shown for your inability to submit such claims or to have such claims submitted by someone else on your behalf), under any insurance policy, bond, fund, or other *arrangement required* by any motor vehicle insurance law requiring the provision of benefits for personal Injury without regard to fault. The benefits of the Plan will not be offset if the provisions of such law require that other insurance benefits be utilized before benefits are available pursuant to such law or you have obtained no-fault insurance at a lower cost because of your coverage under the Plan.

If it is determined that benefits under this Plan should have been reduced because of benefits provided under any insurance policy, bond, fund, or other arrangement required by any motor vehicle insurance law, the University will have the right to recover from the covered employee, any payment already made which is in excess of the University's liability under the Plan. Similarly, whenever benefits which are payable under this Plan have been paid under another group plan, the University may make reimbursement directly to the insurance company or other organization providing benefits under the other plan.

For the purpose of this provision, North American Benefits Network, as Claims Administrator for the University, may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information which may be necessary regarding coverage, expenses and benefits.

Any person claiming benefits under the Plan shall provide to North American Benefits Network such information as may be necessary for the purpose of administering this provision.

## SUBROGATION PROVISION

### RIGHT OF SUBROGATION AND REFUND

**When this provision applies.** The Covered Person may incur dental charges due to injuries which may be caused by the act or omission of a third party or a third party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that third party, or insurer, for payment of the dental charges. Accepting benefits under this Plan for those incurred dental expenses automatically assigns to the Plan any rights the Covered Person may have to recover payments from any third party or insurer. This subrogation right allows the Plan to pursue any claim which the Covered Person has against any third party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the third party or insurer, but in any event, the Plan has a lien on any full or partial amount recovered by the Covered Person whether or not designated as payment for dental expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

- (1) automatically assigns to the Plan his or her rights against any third party or insurer when this provision applies; and
- (2) must repay to the Plan the benefits paid on his or her behalf out of any full or partial recovery made from the third party or insurer.

**Amount subject to subrogation or refund.** The Covered Person agrees to recognize the Plan's right to subrogation and reimbursement. These rights provide the Plan with a priority over any funds paid by a third party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-dental charges, attorney fees, or other costs and expenses. The Plan expressly disclaims any liability to share in the legal costs or fees that may be incurred by a Covered Person or dependent in securing a recovery from a third party.

Notwithstanding its priority to funds, the Plan's subrogation and refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. However, the Plan's right to subrogation still applies if the recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to subrogate.

**Defined terms:** "Recovery" means any monies paid (full recovery or partial recovery) to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injuries or Sickness whether or not said losses reflect dental charges covered by the Plan.

"Subrogation" means the Plan's right to pursue the Covered Person's claims for dental charges against the other person.

“Refund” means repayment to the Plan for dental benefits that it has paid toward care and treatment of the Injury or Sickness.

**Recovery from another plan under which the Covered Person is covered.** This right of refund also applies when a Covered Person makes a full or partial recovery under an uninsured or underinsured motorist plan, homeowner’s plan, renter’s plan or any liability plan.

**Assignment of Rights.** As a condition to the Plan making payments for any dental charges, the Covered Person must assign to the Plan his or her rights to any recovery arising out of or related to any act or omission that caused or contributed to the Injury or Sickness for which such benefits are to be paid. The scope of this assignment is consistent with the amount subject to subrogation or refund set forth above.

## GENERAL PROVISIONS

### How To Apply For Benefits

If you receive Covered Services from a Provider, you should pay any amount for which you are responsible. Generally, you should pay any amount in excess of the benefit limitations at the time the services are rendered unless you have made other arrangements. Panel Providers will submit your claim for you and will be reimbursed directly by the Plan.

### Notice of Claim: Claim Forms

A claim must be filed with the Plan in order for you to receive benefits. Claim forms for Covered Services can be obtained through a Benefits Representative.

### Proof of Claim or Loss

The Plan is not liable for payment of a charge incurred unless written proof is submitted that Covered Services have been given to a Covered Person and that the Covered Person is obligated to pay. In the event that a Provider waives any part of the charge for a treatment, service or supply provided to a Covered Person, the amount paid by the Plan will be reduced accordingly. Acceptable proof of loss means that the Covered Person submits a properly receipted bill with the claim form. Cash register receipts and canceled checks will not be accepted as documentation of charges incurred. The bill submitted by the Covered Person must clearly set forth:

- the name of the person or organization providing the Covered Service;
- the name of the Covered Person who incurred the charge;
- a description of the treatment, service or supply provided;
- the charge incurred for the Covered Service;
- the date the charge was incurred; and any other information required to properly adjudicate the claim.

### When Claims Must Be Filed

Claims must be filed with the Claims Administrator no later than two (2) years from the date the claim is Incurred. Claims filed later than that date may be declined **unless** the person is not legally capable of submitting the claim.

### Claim Review

When a claim is submitted, the Claims Administrator will review the claim to ensure that all conditions for coverage were satisfied. The fact that a treatment, service, or supply was recommended or prescribed by a Provider does not mean the treatment, service, or supply is automatically a Covered Service. The Claims Administrator will also determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

## **Information Required**

The Covered Person must allow the University or its Claims Administrator to review his/her dental records if coverage is to be provided. You can be assured that this information will be used only to administer benefits.

Sometimes other insurance information will be needed before coverage can be provided. This is usually about Coordination of Benefits, subrogation, or the eligibility of certain dependents. Any person claiming benefits under the Plan shall provide to the Claims Administrator, such information as may be necessary for proper review.

## **Denial of Claims**

If a claim is denied, you will be provided with the specific reason(s) for denial with reference to the Plan provision, if any, on which the denial is based. If a claim is denied because of failure to provide adequate information, you will be provided a description and explanation of any additional information needed to complete the claim.

## **Limitation of Actions**

No legal action may be taken by a Covered Person to recover benefits within 60 days after proof of loss has been given. Also, no such action may be taken later than three years after expiration of the time within which proof of loss is required.

## **Appeals Procedure**

If a claim is denied under the Plan for any reason, you have the right to appeal. Appeals regarding claims under the Plan must be received within 45 days of the denial. You may either contact a Benefits Representative who will request a review on your behalf, or you can directly request a review from the University's Claims Administrator at the address shown below. This request should include your social security number and any other information that you feel affects your claim or will facilitate a decision.

North American Benefits Network  
P. O. Box 94928  
Cleveland, Ohio 44101-4928

Upon completion of the review, the decision and an accompanying explanation will be communicated in writing by North American Benefits Network to you directly, or to your Benefits Representative if he or she had requested the review for you. The Representative would then contact you with the results.

## **Fraudulent Claims**

Any Covered Person who knowingly submits, or causes to be submitted, a fraudulent claim will lose all benefits under the Plan and, if an Eligible Employee, may be subject to other disciplinary action.

## **COBRA CONTINUATION OPTIONS**

### **(Who May Continue Coverage, When, and For How Long)**

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), requires that most employers sponsoring a group health/dental plan ("Plan") offer employees and their families covered under their health/dental plan the opportunity for a temporary extension of health/dental coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

**What is COBRA continuation coverage?** COBRA continuation coverage is group health/dental plan coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the employer's Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated nonCOBRA beneficiaries).

**Who is a Qualified Beneficiary?** In general, a Qualified Beneficiary is:

- (1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered employee, the spouse of a covered employee, or a dependent child of a covered employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2) Any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (3) A covered employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the employer, as is the spouse, surviving spouse or dependent child of such a covered employee if, on the day before the bankruptcy Qualifying Event, the spouse, surviving spouse or dependent child was a beneficiary under the Plan.

The term "covered employee" means an employee who has met the eligibility requirements of this Plan and whose coverage has become effective.

An individual is not a Qualified Beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual's employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then a spouse or dependent child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

**What is a Qualifying Event?** A Qualifying Event is any of the following if the Plan provides that the Plan Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (1) The death of a covered employee.
- (2) The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of a covered employee's employment.
- (3) The divorce or legal separation of a covered employee from the employee's spouse.
- (4) A covered employee's enrollment in the Medicare program.
- (5) A dependent child's ceasing to satisfy the Plan's requirements for a dependent child (e.g., attainment of the maximum age for dependency under the Plan).
- (6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an employer from whose employment a covered employee retired at any time.

If the Qualifying Event causes the covered employee, or the spouse or a dependent child of the covered employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met. Any increase in contributions that must be paid by a covered employee, or the spouse or a dependent child of the covered employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered employee and family members will be entitled to COBRA continuation coverage even if they failed

to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

**What is the election period and how long must it last?** An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

**Is a covered employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?** In general, the employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

- (1) A dependent child's ceasing to be a dependent child under the generally applicable requirements of the Plan.
- (2) The divorce or legal separation of the covered employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

**Is a waiver before the end of the election period effective to end a qualified beneficiary's election rights?** If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the employer or Plan Administrator, as applicable.

**When may a Qualified Beneficiary's COBRA continuation coverage be terminated?** During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the employer ceases to provide any group health/dental plan (including successor plans) to any employee.

- (4) Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
  - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
  - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated nonCOBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

**What are the maximum coverage periods for COBRA continuation coverage?** The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered employee ends on the later of:
  - (a) 36 months after the date the covered employee becomes enrolled in the Medicare program; or
  - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered employee's termination of employment or reduction of hours of employment.
- (3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered employee ends on the date of the retired covered employee's death. The maximum coverage period for a Qualified Beneficiary who is the spouse, surviving spouse or dependent child of the retired covered employee ends on the earlier of the date of the Qualified

Beneficiary's death or the date that is 36 months after the death of the retired covered employee.

- (4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

**Under what circumstances can the maximum coverage period be expanded?** If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event.

**How does a Qualified Beneficiary become entitled to a disability extension?** A disability extension will be granted if an individual (whether or not the covered employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage.

**Can a Plan require payment for COBRA continuation coverage?** Yes. For any period of COBRA continuation coverage, a Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension. A group health/dental plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that qualified beneficiary.

**Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?** Yes. The Plan is also permitted to allow for payment at other intervals.

**What is Timely Payment for payment for COBRA continuation coverage?** Timely Payment means payment that is made to the Plan by the date that is 30 days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the employer and the entity that provides Plan benefits on the employer's behalf, the employer is allowed until that later date to pay for coverage of similarly situated nonCOBRA beneficiaries for the period. Notwithstanding the above paragraph, a Plan cannot require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the

date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A 'reasonable period of time' is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

**Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?** If a Qualified Beneficiary's COBRA continuation coverage under a group health/dental plan ends as a result of the expiration of the applicable maximum coverage period, the Plan must, during the 180- day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated nonCOBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

## **CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA (What You Have The Right To Expect)**

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

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

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

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to \$110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, that participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The

court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), that Plan Participant should contact either the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, at 200 Constitution Avenue, N.W., Washington, DC 20210.

## PLAN INFORMATION

**NAME OF PLAN:** The Case Western Reserve University  
DenteMax™ Dental Plan

**PLAN SPONSOR** Case Western Reserve University

**PLAN ADMINISTRATOR:** Case Western Reserve University  
10900 Euclid Ave.  
Cleveland, Ohio 44106-7047

### EMPLOYER IDENTIFICATION

**NUMBER FOR IRS:** 34-1018992

**AGENT FOR SERVICE  
OF LEGAL PROCESS:** Case Western Reserve University  
10900 Euclid Ave.  
Cleveland, Ohio 44106-7047

**PLAN YEAR:** The Plan's fiscal records are maintained  
on a January 1 through December 31 basis.

**FUNDING  
ARRANGEMENT** The Plan is self-funded by  
Case Western Reserve University

**TYPE OF ADMINISTRATION:** Claims administration is provided under an  
"Administrative Services only" arrangement  
with North American Benefits Network, Inc.  
The Plan is not insured.

This Booklet summarizes the highlights of the Case Western Reserve University  
DenteMax™ Dental Plan.

If you have any questions concerning this Plan, need assistance in filing a claim, or if  
you would like information as to whether a specific service would be covered, please  
contact your Human Resources Department or:

North American Benefits Network, Inc.  
PO Box 94928  
Cleveland, Ohio 44101-4928  
440-356-8212  
Toll Free: 1-877-801-1500