Mercer-Auglaize Employee Benefit Trust
Mercer-Auglaize School Consortium
Employee Dental Plan

EFFECTIVE DATE: January 1, 2015

DENTAL CLAIMS ADMINISTERED BY:

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I. INTRODUCTION

The purpose of this document is to provide you and your covered Dependents, if any, with summary information on benefits available under the **Mercer-Auglaize Employee Benefit Trust Employee Dental Plan** (the **"Plan"**) for the **Mercer-Auglaize County School Consortium** ("**Employer**"), as well as information on a Covered Person's rights and obligations under the Plan. Please read this document carefully and contact your Treasurer's office if you have questions.

The **Mercer-Auglaize Employee Benefit Trust** is named the Plan Administrator for this group dental Plan. The Plan Administrator has retained the services of an independent Third Party Administrator, **Superior Dental Care, Inc.** (hereinafter **"SDC"** or "**Claims Administrator**") to process claims and handle other duties for this self-funded Plan. SDC, as Claims Administrator, does not assume liability for benefits payable under this Plan as they are solely claims paying agents for the Plan Administrator. If applicable, the Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 ("**ERISA"**) and its amendments.

This document summarizes the benefits and limitations of the Plan and is known as a Summary Plan Description ("**SPD**"). It is being furnished to you in accordance with ERISA, if applicable.

This document becomes effective on **January 1, 2015**.

II. COST

You are responsible, if applicable, to pay your Participant Contribution and out-of-pocket expenses for the coverage of you and your Dependents. These out-of-pocket expenses can include, but may not be limited to, full charges for services that are not covered benefits under this Plan.

III. ELIGIBILITY

Upon enrollment in the Plan, you, your Spouse and your Eligible Dependents shall become Participants eligible for the benefits provided by this Plan, subject to the limitations contained in the applicable Plan provisions.

Dependent Eligibility

You may enroll yourself in this Plan alone or you may enroll Eligible Dependents. An Eligible Dependent includes:

- The Card Holder's Spouse:
  The term 'spouse' means the spouse of the Employee under a legally valid existing marriage unless a court ordered separation exists; and

- The Card Holder's child:
  The term 'child' means the Employee's natural child, stepchild, legally adopted child, child placed for adoption, foster child, child for whom the Employee or covered spouse has been appointed legal guardian, provided the child is less than twenty-four (24) years of age, and a child who is required to receive coverage under court order.

NOTE: The Plan will allow coverage up to age 24 regardless of the child's availability to obtain employer sponsored coverage and regardless of cost.

Eligibility will continue past age 24 for unmarried Dependent children who are primarily dependent upon the Card Holder or the Card Holder's Spouse for support due to a physical handicap or developmental disability which renders them Totally Disabled. This incapacity must have started before the age limit was reached, the Eligible Dependent must have been continuously covered by this coverage until he or she reached the age limit

and the Dependent's status must be medically certified by a Physician. You must notify your Group of the Eligible Dependent's desire to continue coverage within 30 days of reaching the limiting age. A non-permanent Total Disability where medical improvement is possible is not considered to be a 'handicap' for purposes of this provision. This includes Alcoholism and Drug Abuse and non-permanent mental impairments.

You may be required to submit proof, upon request by the Plan or the Claims Administrator, that a child satisfies these eligibility criteria.

The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have a notice obligation to inform the Plan should the Dependent's eligibility status change throughout the Plan year. Please notify your plan Treasurer regarding status changes.

IV. ENROLLMENT

Participant and Dependent Coverage

In order to be covered by the Plan, you should timely enroll yourself and any Eligible Dependents in the Plan by enrolling in Benefits Connect within 30 days of the date you become eligible for coverage.

Eligible Employees as described in Employee Eligibility are covered, as of the first day of employment, provided the Employee has enrolled for coverage as described within this document subject to any applicable waiting periods. If you enroll after the initial 30-day enrollment period, you must follow the open enrollment or specialized enrollment procedures.

If you gain a new Dependent as a result of marriage, birth, adoption or Placement for Adoption, you will be able to enroll your Dependent in dental coverage at that time. You should request enrollment within 30 days after the marriage, birth (if your birth Child), adoption or Placement for Adoption in your family.

Open Enrollment

The Plan will have an annual open enrollment period in **November** during which eligible persons can be enrolled in the Plan. Coverage for any person for whom you apply under the Plan during open enrollment will begin the **first day of the following January**.

Changing Your Coverage

In addition to the Open Enrollment Period, Federal law allows you to make changes to your elections under this Plan under the following circumstances:

- You qualify for a special enrollment under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");
- You have a "change in status" that affects your eligibility or that of your spouse or Dependent;
- The plan administrator receives a court order such as a Qualified Medical Child Support Order; or
- You, your spouse or your Dependent qualifies for Medicare or Medicaid.

If you qualify to make a change, you must complete the changes in BenefitsConnect or with a paper election form within 30 days of the date of the event causing the change.

Special Enrollments under HIPAA

If you elect no coverage under the Plan for yourself and/or your Dependents (including your spouse) because you have other dental insurance coverage, you may be able to enroll yourself and your Dependents under the Plan in the future if that other coverage ends as long as:

- You submitted this reason in writing to your Employer at the time you declined coverage; and
- You must also request to enroll in the Plan within 30 days of the date your other coverage ends.

In addition, if you gain a new Dependent as the result of marriage, birth, adoption or legal placement in your family, you may be able to enroll yourself and your Dependents (including your spouse). You must request to enroll the Dependent within 30 days of the event.

Change in Status

You may change your elections to the Plan if:

- You get married, divorced, legally separated or have your marriage annulled;
- You have a baby, adopt a Child, have a Child placed with you for adoption or your spouse or a Dependent dies;
- You, your spouse or your Dependent start or end employment;
- Your work schedule or that of your spouse or Dependent changes (because of a switch from part-time to full-time or vice versa, a strike or lockout or the start of or return from an unpaid Leave of Absence); or
- Your Dependent becomes eligible or ineligible for coverage because he or she reaches the Plan's eligibility age limit.

In these situations, you may change your coverage only if:

- The change in status causes you, your spouse, or your Dependent to lose or gain eligibility for dental coverage under the Plan or under your spouse's or Dependent's dental plan; and
- Your election change is consistent with the gain or loss of coverage.

Additionally, you must submit your request for change within 30 days of the event. If you do not request a change during the 30-day period you cannot make a coverage change until the next annual open enrollment period, unless you once again have a situation that qualifies for a mid-year election change.

The Plan may not restrict coverage of any Dependent Child adopted by a Participant, or Placed for Adoption with a Participant, solely on the basis of the Child's pre-existing condition at the time the Child would otherwise become eligible for coverage under the Plan, if the adoption or Placement for Adoption occurs while the Participant is eligible for coverage under the Plan.

Qualified Medical Support Court Orders

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

Medicaid/Medicare

You may submit a written application of coverage under the Plan within 60 days of the date you and/or your Dependent first become eligible for coverage under a state Medicaid or Children's Health Insurance Program ("CHIP"), or, if covered, become ineligible for coverage through these programs. You and any eligible family member who becomes eligible or loses eligibility through these programs are eligible to enroll during this special enrollment period. Coverage will become effective on the date of eligibility or ineligibility for Medicaid or CHIP.

V. TERMINATION OF COVERAGE

Employee Coverage will terminate at the end of the month that employment ends.

Dependent Coverage– as of midnight on the earliest of the following dates:

- When the Employee's coverage terminates;
- When the Employee ceases to make the required contribution regarding Dependent coverage;
- The last day of the Calendar month the child reached the limiting age of 24, as described in the

eligibility section;

- The last day of the Calendar Month the Spouse is legally separated or divorced from the Employee; and/or
- When this Plan is terminated and/or discontinued.

VI. EXTENSION OF COVERAGE

Family and Medical Leave Provisions

If the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), the Employer intends to comply fully regarding the maintenance of health benefits during any period that an eligible employee takes a Leave of Absence in accordance with the Employer's FMLA policy. In applicable situations, FMLA allows an eligible employee to maintain group health plan coverage at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of the leave. Employee eligibility requirements, the obligations of the Employer and employees concerning conditions of leave, and notification and reporting requirements are specified in the Employer's FMLA policy.

If the Employer is subject to FMLA, any Plan provision that conflicts with FMLA is superseded by FMLA. Questions regarding rights and/or obligations under FMLA should be directed to an Employer representative or the Plan Administrator.

Uniformed Services Employment and Reemployment Rights Act of 1994

If you are no longer Actively At Work because of your Service in the Uniformed Services, you can elect, under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") to continue you and your Dependent coverage under the Plan for up to 24 months after coverage would otherwise have terminated. This period of continued coverage will run concurrently with any continuation for which you or your Dependent would have been entitled to under the provisions of COBRA continuation coverage due to your termination or reduction in hours of employment.

If your Service in the Uniformed Services is for 30 days or more, your Participant Contribution for continued coverage will be 102% of the full cost of the coverage. If your Service in the Uniformed Service is less than 30 days, your Participant Contribution will be the same as if you were still an active employee.

If coverage is not continued or your Service in the Uniformed Services exceeds 24 months, upon release from your Service in the Uniformed Services, coverage will be reinstated in the Plan effective the date you are reemployed by the Employer, provided you reapply for employment or report back to work within the applicable time period:

- If the period of service was less than 30 days, the beginning of the next regularly scheduled work period on the first full day after release from Service in the Uniformed Services, taking into account safe travel home plus an eight hour rest period;
- If the period of service was more than 30 days, but less than 181 days, within 14 days of release from Service in the Uniformed Services; and
- If the period of service was more than 180 days, but less than five years, within 90 days of the release from Service in the Uniformed Services.

This period may be extended for up to two years from the date the Service in the Uniformed Services ended if you are unable to return to active employment because of a disability incurred while performing Service in the Uniformed Services.

The Plan Administrator reserves the right to request verification of any Service in the Uniformed Services, including copies of military orders or the applicable Form DD 214.

VII. SCHEDULE OF DENTAL BENEFITS

	In Network	***Out of Network***
Preventive	**100%**	**100%**
Basic	**80%**	**80%**
Major	**60%**	**60%**
Contract Maximum	**$1500.00**	**$1500.00**
Deductible (applies to Basic and Major Services)	**N/A**	**N/A**
Orthodontia	**60%**	**60%**
Lifetime Ortho Max	**$1500.00**	**$1500.00**
Copay (applies to eligible oral evaluations)	**N/A**	**N/A**

This Schedule of Dental Benefits is intended to provide only a general description of your dental benefits under the Plan. The Plan contains limitations and restrictions that are described in Article IX and could affect any benefits that may be payable.

The Plan provides you with access to a Preferred Provider dental network through **Superior Dental Care's** (SDC) Preferred network of Participating Dentists. Under the Plan, SDC offers an open access network that lets Covered Persons seek care from any Dentist whether or not they have entered into an agreement with SDC to provide dental services through its preferred network. The Plan Administrator can provide you with more information regarding the Preferred Provider network. You can also get information about SDC's Preferred network at www.superiordental.com or by calling SDC's customer service at **1-800-762-3159**.

Coinsurance Amounts and Maximum Benefits

Payment for services will be paid at the percentage listed in this Schedule of Benefits. No Benefits will be paid in excess of the maximum benefit amount. The payable benefit (the specific percentage of Covered Expenses that the Plan will pay) varies as to the Class of dental services provided (Preventive, Basic, Major or Orthodontia).

Allocation and Apportionment of Benefits

The Claims Administrator may allocate the Deductible amounts to any eligible charges and apportion the benefits to you. The allocation and apportionment will be binding upon you. There are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is complete.

Many times claims for Covered Expenses are not submitted in the same order in which they were Incurred. Regardless of the order in which the claims were Incurred, Coinsurance will be applied to Covered Expenses in the order that the claims were submitted and ready for payment.

Predetermination of Benefits

Before starting a course of treatment for which the charge is expected to be $400.00 or more, a dental treatment plan is necessary and should be submitted in an acceptable form to the Claims Administrator, **Superior Dental Care, Inc., 6683 Centerville Business Parkway, Centerville, Ohio 45459**. A predetermination of benefits under the Plan will then be provided. (**Please note:** the predetermination process does not apply to Emergency treatment.)

The dental treatment plan should consist of:

- A list of the services to be performed, using the American Dental Association nomenclature and codes;
- A written description of the proposed treatment from the treating Dentist;
- Supporting pre-treatment x-rays showing the your or your Dependent's dental needs;
- The itemized cost of the proposed treatment; and
- Any other appropriate diagnostic materials requested by the Claims Administrator.

A predetermination of benefits is not a guarantee of payment under the Plan. Actual benefits will be based on the services performed, the status of the applicable Deductible and benefit maximums at the time the claim is processed, and the patient's eligibility and the Plan provisions at the time the charges are Incurred.

If a description of the procedures to be performed, x-rays and estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot be reasonably made, the benefits may be for a lesser amount than would otherwise have been payable.

Alternate Benefit Provisions

If two or more services are considered to be acceptable to correct the same dental condition, the Covered Expenses will be based on SDC's Fee Maximum Schedule charge for the least expensive service that will produce a professional satisfactory result, as determined by the Plan Administrator, using guidelines established by the American Dental Association. If you or your Dependent and the Dentist elects the more expensive treatment, any additional amount beyond that approved by the Plan will be your responsibility, in addition to any applicable Deductible or your share of the Coinsurance.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the allowances for an amalgam filling. The patient will be responsible for the difference in cost.

VIII. COVERED DENTAL EXPENSES FOR PARTICIPANTS AND DEPENDENTS

Covered dental charges are the usual and customary charges made by a Dentist or other physician for necessary care, certain preventive services and Appliances or other dental materials for the treatment of a Dental Disease or Disorder or a Dental Injury based on SDC's Fee Maximum Schedule.

Preventive and Diagnostic Services – Non-Orthodontic

Prophylaxis - limited to a total of 2 prophylaxes within the contract period.

Fluoride treatment, topical application - limited to covered persons under age 15 and limited to 1 treatment(s) within the contract period.

Office visits, oral evaluations, examinations or limited problem focused re-evaluations - limited to a total of 2 within the contract period.

Minor emergency treatment – for the relief of pain, bleeding or swelling, but not the cure of the disease.

Bitewing X-rays – up to four (4) Bitewings per contract period.

Full Mouth X-rays or Panoramic Survey – once in five (5) years.

Intraoral Periapical X-rays – three (3) per contract period.

Basic Services

Specialist Examinations - limited to one consultation for endodontics, periodontics or oral surgery per contract period.

Space Maintainers - limited to covered persons under age 19 and limited to one (1) appliance per lifetime per area.

Oral Surgery (includes local anesthesia and routine postoperative care)

- Extractions (not to include pre-orthodontic which are included under the Major category)
- Removal of Periapical and Follicular Cysts
- Intraoral Incision and Drainage
- Exposure of Tooth to Aid Eruption
- Frenectomy
- General Anesthesia or IV Sedation – when provided in connection with oral surgery (excluding simple extractions)

Endodontics (includes local anesthesia, x-rays and routine postoperative care)

- Root Canal Treatment – once in three (3) years per tooth
- Surgical Endodontics – once per lifetime per tooth

Restorative Services – includes local anesthesia

- Amalgam/Composite Restorations – once in three (3) years per surface
- Sedative Filling – once in three (3) years per tooth
- Pins – once in three (3) years per tooth
- Prefabricated Crowns – replaceable after three (3) years in existence
- Recementation (onlays, crowns and bridges) – once in two (2) years

Repairs (includes repairs to crowns, bridges and complete or partial dentures) – once in two (2) years.

Major Services

Periodontics/Surgical Periodontics – includes local anesthesia and postoperative care

- Periodontal Scaling and Root Planing – each quadrant once in two (2) years
- Periodontal Maintenance (root planing followed by osseous surgery in a single course of treatment) – eligible twice within two (2) years during a course of full mouth periodontal treatment
- Complete Occlusal Adjustment – once in two (2) years following periodontal surgery
- Gingivectomy – each quadrant/area once in two (2) years
- Gingival Grafts – each quadrant/area once in two (2) years
- Osseous Surgery – each quadrant/area once in two (2) years

Oral Surgery

- Pre-orthodontic extractions of permanent teeth,
- Alveoplasty, Vestibuloplasty – once in eight (8) years
- Removal of Exostosis or Tori

Dental Sealants (posterior permanent teeth only) – once per lifetime per tooth for children under age 15

Prosthodontics

- Bridge Abutments (see crowns and onlays) – replaceable after eight (8) years in existence
- Pontics (see Crowns and Onlays) – replaceable after eight (8) years in existence
- Removable Partial Dentures – replaceable after eight (8) years in existence
- Complete Dentures – replaceable after eight (8) years in existence
- Rebasing – replaceable after eight (8) years in existence
- Relining – once in three (3) years

Crowns and Onlays (treatment for decay or traumatic injury and when teeth cannot be restored with a filling material or when the tooth is an abutment; applies interchangeably to onlays, crowns, abutments and pontics for the same tooth)

- Crowns – once in eight (8) years on the same tooth and replaceable after eight (8) years in existence
- Onlays - once in eight (8) years on the same tooth and replaceable after eight (8) years in existence
- Post and Core - once in eight (8) years on the same tooth and replaceable after eight (8) years in existence

Orthodontic Services

Orthodontic benefits include orthodontic procedures under a "Treatment Plan" that has been evaluated through a pre-determination of benefits by SDC. The dentist providing this service must supply SDC with films and study models upon request.

The one-time Record/Diagnosis fee shall consist of the initial exam, diagnosis and consultation, x-rays, and study models. This fee can be submitted for payment separately from the treatment plan and will apply to the member's lifetime maximum. Payments for orthodontic treatment will be made monthly beginning after the first month of treatment, and continue for the estimated duration of the treatment plan, as long as the patient is a member of SDC and in active treatment. Patients in retention are not covered.

For orthodontic treatment in progress at the time of eligibility, SDC will review the initial estimate of treatment months and total cost to determine benefit eligibility. This calculation will be based on the appropriate plan percentage, up to the plan's allowable orthodontic lifetime maximum, and for the remaining months of estimated treatment. Benefits will automatically terminate when the patient ceases to be eligible.

IX. PLAN EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to dental expenses Incurred by all Participants and Dependents under the Plan. Any exclusion listed below will not apply to the extent that coverage for the service or supply is specifically provided under the Plan, or that the exclusion is prohibited under any applicable law:

- Any service or supply which is not specifically listed in this plan's List of Covered Dental Services
- Services performed for cosmetic reasons, including personalization or characterization of dentures
- Services or supplies that are considered experimental according to standard dental practice
- Services or procedures started prior to the effective date of coverage. Prosthetic devices and crowns will not be covered if impressions are taken before the effective date of coverage
- Services or procedures completed after the date of termination, unless stated elsewhere in this certificate
- Missed appointment charge
- Replacement of lost or stolen prosthetic devices unless it is after the limitation date
- Analgesics or other drugs and prescriptions
- Hospital related charges

- Appliances or restorations, other than full dentures, for the primary purpose of increasing vertical dimension or restoring occlusion
- Any restoration done for reasons of erosion, abrasion, and/or wear
- Veneers
- Inlays and related services
- Crown lengthening
- Services for educational purposes
- Splinting
- Services covered under Workers Compensation, Federal or State agencies
- Services performed by other than a licensed dentist, except for legally delegated services to a licensed dental hygienist or licensed expanded functions auxiliary
- Surgery, treatment and x-rays for Craniomandibular disorders (TMJ)
- Orthognathic surgery
- Crowns or Onlays for teeth where there is no opposing tooth
- Laboratory charges
- Services performed on a tooth with poor prognosis
- Coverage for permanent crowns and prosthetics for members under the age of 17
- Services performed for which no payment would normally be required
- Temporary/Provisional Services
- Implants and related services
- Appliances or devices such as occlusal guards, bite planes, tongue thrust, etc. used for the primary purpose of correcting harmful habits such as: grinding or clenching of teeth, tongue thrust, or thumb sucking, etc.

X. CLAIM PROCEDURES

You do not have to file a claim form when seeking care from a Participating Dentist. The Participating Dentist will seek compensation for covered services solely from SDC, except for the out-of-pocket expenses that are directly payable by you to the Dentist and Deductibles, and payment always goes to the provider of dental services. It is your responsibility to show your SDC identification card to your Participating Dentist before you receive care. This will expedite the claims process because claims must be submitted and resolved within one year from the date of service to be considered for payment, regardless of enrollment status

A Non-Participating Dentist is not required to submit a claim form on your behalf and you may be responsible for submitting your own claim form when seeking care from a Non-Participating Dentist. A Non-Participating Dentist may seek total compensation for services prior to the submission of a claim form. These claims must also be submitted and resolved within one year from the date of service to be considered for payment, regardless of enrollment status. These claims payments are directed to the Participant.

If you have any questions regarding claims submission, **please contact SDC between the hours of 7:30 a.m. to 5:00 p.m. (Eastern Time) at 1-800-762-3159**. SDC may also be contacted by fax at **937-291-8695**.

Claims Review Process

The Plan Administrator has delegated the responsibility for evaluating all claims for benefits to SDC. SDC will review your claim and notify you and your Dentist (when appropriate) of its decision to approve or deny your claim.

Notice of Adverse Benefit Determination

If a claim for benefits is denied in whole or in part, SDC will notify you and your Dentist in writing in the form of an Explanation of Benefits or Claim Voucher Statement. The notice will be issued within 30 day after the claim is filed unless special circumstances require an extension of time of up to fifteen (15) days. If SDC needs an extension, it will notify you within the initial thirty (30) day period and state the reason why the extension is needed and when it will make its determination. If an extension is needed because you or the Dentist did not provide sufficient information or filed an incomplete claim, you will have forty five (45) days from the date you or your Dentist receives the notice requesting additional information in which to do so.

If SDC denies your claim in whole or in part, the notice of the claim decision will state: The specific reason(s) why the claim was denied, including a reference to specific plan provisions on which the denial is based; whether a specific rule, guideline or protocol was relied upon in making the adverse benefit decision and that a copy will be provided free of charge upon request; a description of any additional information needed in order to perfect the claim and the reason why such information is necessary; and a description of the Plan's informal and formal claims review process and the time limits applicable to the process, including a statement of your right to bring a civil action under ERISA.

Request for Informal Review or Reconsideration

If you or your Dentist disagrees with SDC's adverse benefit determination, either may within 60 days of the mailing date of the Explanation of Benefits file a written request to SDC for informal review (reconsideration) of the adverse benefit determination. SDC will issue its decision on the informal review within 60 days after the request for informal review is received. You are not required to request reconsideration before requesting formal review. Any appeal relating to the original decision or the informal review decision must be made within 180 days following the mailing date of the original adverse benefit determination.

Request for Formal Review or Appeal and Appeal Procedures

If you or your Dentist disagrees with SDC's adverse benefit determination, you may appeal the determination to SDC within 180 days following the mailing date of the adverse benefit determination. The appeal must be in

writing and must state why it is believed that SDC's benefit decision was incorrect. The denial notice as well as any other documents or information bearing on the claim should accompany the appeal request. SDC's review of the claim upon appeal will take into account all comments, documents, records or other information submitted by you or your Dentist, regardless of whether that information was submitted or considered in the initial benefit determination.

SDC's review on appeal will be conducted by a person who is neither the individual who made the initial claim denial nor the subordinate of that individual. If the review is of an adverse benefit determination based in whole or in part on a determination related to dental necessity, experimental treatment or a clinical judgment in applying the Plan's terms, SDC will consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the person who made the initial claim denial nor the subordinate of that individual. Upon request, SDC will provide the name of any dental consultant whose advice was obtained in connection with the claim denial, whether or not that advice was relied upon in making the initial benefit determination.

SDC will notify you and your Dentist in writing of its decision on the formal appeal within 30 days after the appeal is filed unless special circumstances require an extension of time of up to 60 days. If SDC needs an extension, it will notify you within the initial 30-day review period and state the reason why the extension is needed and when it will make its determination.

If SDC denies the claim on appeal, SDC will send you a final written decision that states the reason(s) why the claim you appealed is being denied. The decision will contain references to any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criteria was relied upon in denying the claim on appeal, the final written decision will state the rule, guideline, protocol or other criteria or indicate that such rule, guideline, protocol or other criteria was relied upon in making the decision on appeal and you may request a copy free of charge. Upon written request, SDC will provide you free of charge with copies of documents, records and other information pertinent to your claim.

Predetermination of Benefits

In the case of a request for predetermination of benefits by the Plan, SDC will notify you and the Dentist of its benefit determination, whether adverse or not, within a reasonable period of time appropriate to the circumstances, but not later than 15 days after the referral request is filed. This period may be extended one time by SDC for up to 15 days if necessary due to matters beyond the control of the Plan. If an extension is taken, the Plan Administrator will notify you and your Dentist within the original 15-day period of the circumstances requiring the extension and the date by which the Plan expects to render a decision. If an extension is needed because you and/or the Dentist did not submit information necessary to decide the claim, the notice of extension will specifically describe the required information. You and/or your Dentist will be given at least 45 days from receipt of the notice within which to provide the specified information.

If a predetermination of benefits request requiring pre-authorization is denied, you or your Dentist may appeal this determination in writing to SDC within 180 days following the mailing date of the denial notice. SDC will notify you and your Dentist in writing of its determination on review within 30 days of receipt of the request for review.

Emergency Treatment

In the case of a request for Emergency treatment, SDC will notify you and your Dentist of its benefit determination, whether adverse or not, as soon as possible, but not later than 72 hours after receipt of the treatment request. The notice will include a description of the expedited review and appeal process applicable to urgent care claims. If the Dentist fails to provide sufficient information to decide the claim, SDC will notify you and your Dentist of the specific information required to make a determination on the claim as soon as

possible, but not later than 24 hours after receipt of the claim. SDC then will notify you and your Dentist of its determination as soon as possible, but not later than 48 hours after the earlier of (a.) the Plan's receipt of the specified information or (b.) the end of the period given the Dentist to provide the additional information.

If an expedited review of a claim denial involving Emergency treatment is necessary, a request for such review may be submitted orally or in writing by you and your Dentist by telephone, facsimile or other similarly expeditious method. SDC will notify you and your Dentist of the determination on review as soon as possible, but not later than 72 hours after receipt of the request for review.

XI. COORDINATION OF BENEFITS

The Coordination of Benefits ("COB") provision applies when a person has dental care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each *Plan* will pay a claim for benefits. The *Plan* that pays first is called the *Primary plan*. The *Primary plan* must pay benefits in accordance with its policy terms without regard to the possibility that another *Plan* may cover some expenses. The *Plan* that pays after the *Primary plan* is the *Secondary plan*. The *Secondary plan* may reduce the benefits it pays so that payments from all *Plans* do not exceed 100% of the total *Allowable Expense*.

COB Definitions

A. A *Plan* is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) *Plan* includes: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) *Plan* does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56 ; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate *Plan*. If a *Plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *Plan*.

B. *This plan* means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from *this plan*. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether *This plan* is a *Primary plan* or *Secondary plan* when the person has health care coverage under more than one *Plan*.

When *This plan* is primary, it determines payment for its benefits first before those of any other *Plan* without considering any other *Plan's* benefits. When *This plan* is secondary, it determines its benefits after those of another *Plan* and may reduce the benefits it pays so that all *Plan* benefits do not exceed 100% of the total *Allowable Expense*.

D. When a *Plan* provides benefits in the form of services, the reasonable cash value of each service will be considered an *Allowable Expense* and a benefit paid. An expense that is not covered by any Plan covering the person is not an *Allowable Expense*. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an *Allowable Expense*.

The following are examples of expenses that are not *Allowable Expenses*:

(1) If a person is covered by 2 or more *Plans* that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an *Allowable Expense*.

(2) If a person is covered by 2 or more *Plans* that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *Allowable Expense*.

(3) If a person is covered by one *Plan* that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another *Plan* that provides its benefits or services on the basis of negotiated fees, the *Primary plan's* payment arrangement shall be the *Allowable Expense* for all *Plans*. However, if the provider has contracted with the *Secondary plan* to provide the benefit or service for a specific negotiated fee or payment amount that is different than the *Primary plan's* payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the *Allowable Expense* used by the *Secondary plan* to determine its benefits.

(4) The amount of any benefit reduction by the *Primary plan* because a covered person has failed to comply with the *Plan* provisions is not an *Allowable Expense*. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Order of Benefit Determination Rules

When a person is covered by two or more *Plans,* the rules for determining the order of benefit payments are as follows:

A. The *Primary plan* pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other *Plan*.

B. (1) Except as provided in Paragraph (2), a *Plan* that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both *Plans* state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the *Plan* provided by the contract holder. Examples of these types of situations are major

medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a *Closed Panel Plan* to provide out-of-network benefits.

C. A *Plan* may consider the benefits paid or provided by another *Plan* in calculating payment of its benefits only when it is secondary to that other *Plan*.

D. Each *Plan* determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The *Plan* that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the *Primary plan* and the *Plan* that covers the person as a dependent is the *Secondary plan*. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the *Plan* covering the person as a dependent, and primary to the *Plan* covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two *Plans* is reversed so that the *Plan* covering the person as an employee, member, policyholder, subscriber or retiree is the *Secondary plan* and the other *Plan* is the *Primary plan*.

(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one *Plan* the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The *Plan* of the parent whose birthday falls earlier in the calendar year is the *Primary plan*; or

- If both parents have the same birthday, the *Plan* that has covered the parent the longest is the *Primary plan*.

- However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the *Plan* of that parent has actual knowledge of those terms, that *Plan* is primary. This rule applies to plan years commencing after the *Plan* is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the

dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The *Plan* covering the Custodial parent;

- The *Plan* covering the spouse of the Custodial parent;

- The *Plan* covering the non-custodial parent; and then

- The *Plan* covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one *Plan* of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The *Plan* that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the *Primary plan*. The *Plan* covering that same person as a retired or laid-off employee is the *Secondary plan*. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other *Plan* does not have this rule, and as a result, the *Plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another *Plan*, the *Plan* covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the *Primary plan* and the COBRA or state or other federal continuation coverage is the *Secondary plan*. If the other *Plan* does not have this rule, and as a result, the *Plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The *Plan* that covered the person as an employee, member, policyholder, subscriber or retiree longer is the *Primary plan* and the *Plan* that covered the person the shorter period of time is the *Secondary plan*.

(6) If the preceding rules do not determine the order of benefits, the *Allowable Expenses* shall be shared equally between the *Plans* meeting the definition of *Plan*. In addition, *This plan* will not pay more than it would have paid had it been the *Primary plan*.

Effect on the Benefits of This Plan

A. When *This plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *Plans* during a plan year are not more than the total *Allowable Expenses*. In determining the amount to be paid for any claim, the *Secondary plan* will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any *Allowable Expense* under its *Plan* that is unpaid by the *Primary plan*. The *Secondary plan* may then reduce its payment by the amount so that, when combined with

the amount paid by the Primary plan, the total benefits paid or provided by all *Plans* for the claim do not exceed the total *Allowable Expense* for that claim. In addition, the *Secondary plan* shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more *Closed Panel Plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *Closed Panel Plan*, COB shall not apply between that *Plan* and other *Closed Panel Plans*.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under *This plan* and other *Plans*. SDC may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under *This plan* and other *Plans* covering the person claiming benefits. SDC need not tell, or get the consent of, any person to do this. Each person claiming benefits under *This plan* must give SDC any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

If the amount of the payments made by SDC is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination of Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. Please see SDC's appeal procedure within this Summary Plan Description. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at http://insurance.ohio.gov.

XII. CONTINUATION OF DENTAL COVERAGE UNDER COBRA

Right to Elect Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), certain employees and their families who have dental coverage under the Plan will be entitled to the opportunity to elect a temporary extension of coverage where coverage under the Plan would otherwise end. The Plan Administrator is responsible for administering COBRA continuation coverage. Complete instructions as well as election forms will be provided by the Plan Administrator to Plan Participants and Dependents who become Qualified Beneficiaries under COBRA. The rest of this Article generally explains COBRA continuation coverage.

If a Qualified Beneficiary loses coverage under the Plan due to a Qualifying Event, he or she may elect to continue coverage under the Plan in accordance with COBRA upon payment of the monthly contribution specified from time to time by the Employer. A Qualified Beneficiary must elect the coverage within the 60

day period beginning on the later of:

- The date of the qualifying event; or
- The date the Qualified Beneficiary was notified of his or her right to continue coverage.

If a Covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their Plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator for more information.

Notification of Qualifying Event

If the Qualifying Event is divorce, legal separation or a Dependent Child's ineligibility under the Plan, the Qualified Beneficiary must notify the Employer, in writing addressed to the Plan Administrator, of the Qualifying Event within 60 days of the event, or 60 days of the date the Qualified Beneficiary would lose coverage because of the event, in order for coverage to continue. Appropriate documentation of the Qualifying Event must be submitted, including, as appropriate, final divorce and legal separation decrees issued and properly signed by the court. In addition, a Totally Disabled Qualified Beneficiary must notify the Employer in accordance with the section below entitled "Total Disability" in order for coverage to continue.

Length of Continuation Coverage

A Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered Employee may continue coverage under the Plan for:

- Up to 18 months from the date of the Qualifying Event; or
- A Qualified Beneficiary who loses coverage due to the Covered Employee's death, divorce, or Medicare eligibility and Dependent Children who have become ineligible for coverage may continue under the Plan for up to 36 months from the date of the Qualifying Event; or
- If a Qualified Beneficiary is Totally Disabled at any time during the first 60 days of Continuation Coverage, he or she may continue coverage for up to 29 months from the date of the Qualifying Event, provided the Qualified Beneficiary notifies the Employer of the determination of his or her Total Disability under the Social Security Act:
    - Before the end of the original 18 month continuation period; and
    - Within 60 days following the date of such determination.

Termination of Continuation of Coverage

Continuation Coverage will automatically end earlier than the applicable 18 or 36-month period for a Qualified Beneficiary if:

- The required monthly contribution for coverage is not received by the Employer within 30 days following the date it is due;
- The Qualified Beneficiary becomes covered under any other Plan containing an exclusion or limitation relating to a Pre-Existing Condition, and such exclusion or limitation applies to the Qualified Beneficiary, then the Qualified Beneficiary will be eligible for Continuation Coverage as long as the exclusion or limitation relating to the Pre-Existing Condition applies to the Qualified Beneficiary;
- For Totally Disabled Qualified Beneficiaries continuing coverage for up to 29 months, the last day of the month coincident with or following 30 days from the date of a final determination by the Social Security Administration that such Qualified Beneficiary is no longer Totally Disabled;
- The Qualified Beneficiary becomes entitled to Medicare benefits; or

- The Employer ceases to offer any Group Health Plans.

Multiple Qualifying Events

If a Qualified Beneficiary is continuing coverage due to a Qualifying Event for which the maximum Continuation Coverage is 18 months, and a second Qualifying Event occurs during the 18 month period, the Qualified Beneficiary may elect, in accordance with the section entitled "Right to Elect Continuation Coverage," to continue coverage under the Plan for up to 36 months from the date of the first Qualifying Event.

Total Disability

In the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act (the "Act") to have been Totally Disabled at the time of a Qualifying Event or at any time during the first 60 days of the Qualified Beneficiary's Continuation Coverage (if the Qualifying Event is termination of employment or reduction in hours), that Qualified Beneficiary may continue coverage (including coverage for Dependents who were covered under the Continuation Coverage) for a total of 29 months as long as the Qualified Beneficiary notifies the Employer, in writing addressed to the Plan Administrator:

- Prior to the end of 18 months of Continuation Coverage that he or she was disabled as of the date of the Qualifying Event; and
- Within 60 days of the determination of Total Disability under the Act.

A copy of the determination letter from Social Security must be submitted with the notification.

The Employer will charge the Qualified Beneficiary an increased contribution for Continuation Coverage extended beyond 18 months pursuant to this Section.

If during the period of extended coverage for Total Disability (Continuation Coverage months 19-29) a Qualified Beneficiary is determined to be no longer Totally Disabled under the Act:

- The Qualified Beneficiary will notify the Employer of this determination within 30 days; and
- Continuation Coverage will terminate the last day of the month following 30 days from the date of the final determination under the Act that the Qualified Beneficiary is no longer Totally Disabled.

Payment of Premiums

The Plan will determine the amount of premium to be charged for Continuation Coverage for any period, which will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.

The Plan may require a Qualified Beneficiary to pay a contribution for coverage that does not exceed 102% of the applicable premium for that period.

For Qualified Beneficiaries whose coverage is continued pursuant to the Section entitled "Total Disability" of this provision, the Plan may require the Qualified Beneficiary to pay a contribution for coverage that does not exceed 150% of the applicable premium for continuation coverage months 19-29.

Contributions for coverage may, at the election of the payer, be paid in monthly installments.

If Continuation Coverage is elected, the first monthly contribution for coverage must be made within 45 days of the date of election.

Without further notice from the Employer, the Qualified Beneficiary must pay the monthly contribution for

coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Employer within 30 days of the payment due date, Continuation Coverage will terminate in accordance with the section entitled "Termination of Continuation Coverage.".

No claim will be payable under this provision for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.

XIII. RECOVERY RIGHTS

Subrogation

The Plan is subrogated to any and all rights of recovery that you or your Dependent has against any third party in connection with the injury or illness with respect to which the payments are made, including claims by you or your Dependent for automobile uninsured and underinsured insurance. In addition, the Plan has the right to be reimbursed from any recovery made by you or your Dependent.

You or your Dependent are obligated to cooperate with the Plan Administrator to do whatever may be necessary to protect the Plan's rights, including signing and delivering any necessary papers. Neither you nor your Dependent will do anything to prejudice the rights of the Plan. It is the responsibility of you and your Dependent to notify the Plan Administrator, in writing, as soon as practicable, of any possible claim against a responsible third party, or any automobile uninsured or underinsured insurance coverage.

To the extent that the insurance available from or on behalf of a third party is insufficient to satisfy in full the Plan's subrogation claim and any claim by you or your Dependent, the Plan's subrogation claim will have priority and will be satisfied in full before any insurance and assets are applied to you or your Dependent's claim.

If you or your Dependent makes any recovery for the injury or illness with respect to which the Plan has made payments, then, to the extent of payments made by the Plan, the Plan will automatically have a lien against any recovery fund. You or your Dependent (or agent, representative or attorney) will hold the money in trust for the Plan and take all appropriate and reasonable steps to immediately repay the Plan.

The Plan's right of recovery under this provision will not be reduced or offset by any of your or your Dependent's claims, any claim of an attorney for attorney's fees, or any expenses incurred in connection with enforcing the Plan's rights of recovery against a third party.

Additional Rights of Recovery

The Plan will comply with Sections 609(b)(1), (2) and (3) of the Employee Retirement Income Security Act with regard to persons eligible for Medicaid. Neither you or your Dependent's eligibility for, or participation in, Medicaid will affect determination of whether or not payments should be made. Under state and federal law, should a person be entitled to payment of a claim under the Plan, and all or part of that claim has been paid by Medicaid, then the state is subrogated to the person's right to payment under the Plan to the extent of the amount paid by Medicaid, and reimbursement will be made in that amount directly to the state.

Facility of Payment

If you or a provider to whom payments are directed to be made is mentally, physically, or legally incapable of receiving or acknowledging receipt of the payments, neither the Plan Administrator nor the Claims Administrator will be under any obligation to see that a legal representative is appointed or to make payments to a legal representative, if appointed. A determination of payment made in good faith will be conclusive on all persons. The Plan Administrator, Claims Administrator or any fiduciary will not be liable to any person as a result of a payment made and will be fully discharged from all future liability with respect to a payment made.

XIV. ADMINISTRATION OF THE PLAN

Plan Administrator as Named Fiduciary

Except as otherwise specifically provided for in the Plan, the Plan Administrator will have the exclusive authority to control and manage the operation and administration of the Plan and will be the Named Fiduciary of the Plan for purposes of any applicable law. The Plan Administrator will have all power necessary or convenient to enable it to exercise its authority. The Plan Administrator may provide rules and regulations, consistent with the provisions of the Plan, for the Plan's operation and management, and may from time to time amend or rescind the rules or regulations. The Plan Administrator may accept service of legal process for the Plan and will have the full discretion, power, and the duty to take all action necessary or proper to carry out the duties required under any applicable law.

The Plan Administrator may delegate duties involved in the administration of the Plan to such person or persons whose services are deemed necessary or convenient; provided, however, that both the ultimate responsibility for the administration of the Plan and the authority to interpret the Plan will remain with the Plan Administrator. The Employer will indemnify any employee to whom duties are delegated by the Plan Administrator pursuant to this section from and against any liability that such employee may incur in the administration of the Plan, except for liabilities arising from the recklessness or willful misconduct of such employee.

Powers of Plan Administrator

The Plan Administrator has the exclusive right, power and authority, in its sole and absolute discretion, to administer and interpret the Plan and other Plan documents. The Plan Administrator has all powers reasonably necessary to carry out its responsibilities under the Plan including (but not limited to) the sole and absolute discretionary authority to:

- Administer the Plan according to its terms and to interpret Plan policies and procedures;
- Resolve and clarify inconsistencies, ambiguities and omissions in the Plan document and among and between the Plan document and other related documents;
- Take all actions and make all decisions regarding questions of coverage, eligibility and entitlement to benefits, and benefit amounts; and
- Process and approve or deny all claims for benefits.

The decision of the Plan Administrator on any disputes arising under the Plan, including (but not limited to) questions of construction, interpretation and administration shall be final, conclusive and binding on all persons having an interest in or under the Plan. Any determination made by the Plan Administrator shall be given deference in the event the determination is subject to judicial review and shall be overturned by a court of law only if it is arbitrary and capricious.

XV. GENERAL PROVISIONS

Non-Alienation and Assignment

The Plan will not be liable for any debt, liability, contract or tort of any Participant or Dependent. The Plan will pay all benefits due and payable for Covered Expenses directly to the Participant who Incurred the Covered Expenses, and no Plan benefits will be subject to anticipation, sale, assignment, transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation or any other voluntary or involuntary alienation or other legal or equitable process not transferable by operation of law. However, a Participant to whom benefits are otherwise payable may assign benefits to a Participating Dentist or other service provider. Such an assignment of benefits by a Participant to a Participating Dentist or other service provider will be binding on the Plan only if:

- The Plan Administrator or Claims Administrator is notified of the assignment prior to payment of benefits;
- The assignment is made on a form provided by, or approved by, the Plan Administrator or the Claims

Administrator; and

- The assignment contains any additional terms and conditions as may be required from time to time by the Plan Administrator or Claims Administrator.

Failure to Enforce

Failure to enforce any provision of the Plan does not constitute a waiver or otherwise affect the Plan Administrator's right to enforce that provision at another time, nor will that failure affect the right to enforce any other provision.

Fiduciary Responsibilities

No fiduciary of the Plan will be liable for any acts or omission in carrying out his, her or its responsibilities under the Plan, except as may be provided under applicable laws. Each fiduciary under the Plan will be responsible only for the specific duties assigned to such fiduciary under the Plan and will not be directly or indirectly responsible for the duties assigned to another fiduciary, except as may be otherwise provided in applicable laws.

Disclaimer of Liability

The Plan is not responsible for the efficiency or integrity of any health care provider delivering services or supplies utilized by the Participant. The Plan is not liable in any way for the effect of delivery of such services or supplies, the results of actions taken as a result of such services or supplies being limited or not covered by the Plan, nor any limitations imposed on the cost sharing responsibility of the Plan.

Nothing contained in the Plan will confer upon a Participant or Dependent any claim, right or cause of action, either at law or at equity, against the Plan, Plan Administrator, Claims Administrator, or any Employer for the acts or omissions of any health care provider from whom a Participant or Dependent receives care, or for the acts or omission of any Physician from whom the Participant or Dependent receives care under the Plan, or for any acts or omissions of any provider of services or supplies under the Plan. Neither the Plan, nor the Plan Administrator, nor the Claims Administrator have any responsibility for or control over the actions of any Preferred Provider networks offering services and/or supplies under the Plan.

Administrative and Clerical Errors

The benefits payable to or on behalf of a Participant or Dependent under the Plan will not be decreased nor increased due to administrative or clerical errors made by the Employer, the Plan Administrator, the Utilization Review Service or the Claims Administrator. If written application for coverage for an eligible employee or Dependent is submitted by the Participant within the applicable time frame specified in Article III, any subsequent administrative or clerical error made by the Employer, the Plan Administrator or the Claims Administrator will not act to delay the effective date of such person's coverage beyond the date such coverage would otherwise become effective if such application was processed in a timely manner. In addition, any such error made in claims processing, utilization review or other administrative functions will not affect the benefits payable to or on behalf of a Participant or Dependent under the Plan. The Plan Administrator may require proof of an error described in this provision. The Plan Administrator will have the sole responsibility to determine when an error is an "administrative or clerical" error and will be the sole judge of any proof required.

Plan Modification, Amendments and Termination

Subject to the provisions of any collective bargaining agreement applicable to any Employee, the Plan Sponsor intends to continue the Plan indefinitely, but reserves the right to amend, modify or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason, by action of the Plan Sponsor in its sole and absolute discretion. However, no amendment, modification or termination may deprive you of any benefit to which you have become entitled, except that an amendment to comply with the requirements of the Internal Revenue Code or other federal or

state law may be made at any time with retroactive effect. Upon termination, the rights of Participants and Dependents to benefits are limited to claims incurred and due up to the date of termination.

The Plan Is Not a Contract

The Plan may not be deemed to constitute a contract between the Employer and any Employee or to a consideration for, or an inducement or condition of, the employment of an Employee. Nothing in the Plan will be deemed to give any Employee the right to be retained in the service of the Employer or the right of the Employer to discharge any Employee at any time. However, the foregoing will not be deemed to modify the provisions of any collective bargaining agreement applicable to any Employee.

XVI. GENERAL PLAN INFORMATION

NAME OF PLAN

The name of the Plan is the **Mercer-Auglaize Employee Benefit Trust Employee Dental Plan**. The benefits described in this document are for dental care.

PURPOSE OF THE PLAN

The Employer executes this document, including any amendments, to establish a health benefit plan for the exclusive benefit of its participating employees and the Eligible Dependents of these, and to grant them legally enforceable rights under the Plan. While the Employer has every intention of continuing the Plan indefinitely, it reserves the right to amend or terminate the Plan, and the benefits provided hereunder, at any time.

The Plan Administrator has issued a plan document and Summary Plan Description to each Participant that summarizes the benefits to which that person is entitled, to whom benefits are payable, and the provisions of the Plan principally affecting the Participant and his or her covered Dependents.

AMENDMENT OR TERMINATION

The Employer may amend or terminate the Plan at any time by means of a writing signed by a person authorized by The Employer to do so. Any such amendment or termination will become effective upon its execution or on such date as may be specified in that writing. Such amendment, modification or termination may result in the termination of Participant and Dependent coverage under the Plan. Expenses Incurred prior to any Plan termination will be paid as provided under the terms of the Plan prior to such termination. Any termination of the Plan will be communicated by The Employer to the Participants.

Upon Plan termination, any Plan assets remaining in the Plan's account(s) will be distributed by the Plan Administrator to the Plan Sponsor and/or Participants, in accordance with method(s) set forth in any applicable law or regulation. The Plan Administrator will pay all eligible Plan benefits and expenses before any distribution is made.

The terms of the Plan cannot be amended or modified by oral statement(s). Only the Plan Administrator can interpret the terms of the Plan.

The Employer reserves the right, at any time and from time to time, to modify or amend, in whole or in part, any or all of the provisions of the Plan.

PLAN ADMINISTRATOR TAX ID NUMBER (EIN)

61-1766196

PLAN ADMINISTRATOR
Mercer Auglaize Employee Benefit Trust
400 Buckeye St.
Rockford, OH 45882
Phone: (419) 363-3045
Fax: (419) 363-2595

PLAN NUMBER (ERISA)
501

PLAN YEAR
The Plan Year is a time period defined for fiscal purposes and used for certain Plan reporting and disclosure requirements.

CALENDAR YEAR
The Calendar Year is the period beginning January 1 and ending December 31 that is used in the application of Coinsurance and benefit maximum amounts.

TYPE OF ADMINISTRATION
The benefits of this Plan are administered by **Mercer-Auglaize Employee Benefit Trust** in accordance with the provisions of the group contract issued by SDC to Mercer-Auglaize School Consortium.

DESCRIPTION OF PLAN
The Plan is an employee health and welfare benefit plan providing dental benefits. A copy of the Plan documents and insurance contracts, if any, are on file at the Plan Administrator's office and may be read by any Covered Person at any reasonable time. In the event of any discrepancy between any summary of the Plan and the actual provisions of the Plan document, the Plan document will govern.

The Plan will not be deemed to constitute a contract between the Employer and any employee or to be a consideration for, or an inducement or condition of, the employment of any employee. Nothing in the Plan will be deemed to give any employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any employee at any time.

NAMED FIDUCIARY
Mercer Auglaize Employee Benefit Trust
400 Buckeye St.
Rockford, OH 45882
Phone: (419) 363-3045
Fax: (419) 363-2595

AGENT FOR SERVICE OF LEGAL PROCESS
Mercer Auglaize Employee Benefit Trust
400 Buckeye St.
Rockford, OH 45882
Phone: (419) 363-3045
Fax: (419) 363-2595

Legal process may be served upon the Plan Administrator or Plan Trustees.

PLAN TRUSTEES
Chairman of the Board of Trustees
Mercer-Auglaize Employee Benefit Trust
400 Buckeye St.
Rockford, OH 45882

FUNDING
The Plan is funded by the Mercer-Auglaize Employee Benefit Trust. Funds for payment of claims considered under the Plan are forwarded to account(s) from which claims are to be paid. All funds received by the Trust and all earnings of the Trust shall be applied toward payment of Plan benefits and reasonable expenses for administration of the Plan. The Board of Trustees may appoint and investment manager(s) to manage any assets of the Plan. Any fiduciary, employee, agent representative, or other person performing services to or for the Plan shall be entitled to reasonable compensation for services rendered and for reimbursement of expenses properly and actually incurred, unless such person is the Employer or already received full-time pay from the Employer. Covered Persons shall only look to the funds in the Trust for payment of Plan benefits and expenses.

ASSIGNMENT
A Covered Person's benefits may not be assigned, except by consent of the Employer, other than to providers of Plan benefits.

SOURCE OF CONTRIBUTIONS
The Plan is funded by contributions made by the Employer and employees who are participating under the Plan. Participant Contributions are currently required for both Participant and Dependent Coverage.

The Plan Trustees will, from time to time, evaluate the funding method of the Plan benefits and determine the amount to be contributed by the Employer and the amount to be contributed, if any, by the Participants for each type of coverage.

CLAIMS ADMINISTRATOR
Superior Dental Care, Inc.
6683 Centerville Business Parkway
Centerville, OH 45459
800-762-3159 (Office)
937-291-8695 (Fax)

PREFERRED PROVIDER DENTAL NETWORK
Superior Dental Care, Inc.
6683 Centerville Business Parkway
Centerville, OH 45459
800-762-3159 (Office)
937-291-8695 (Fax)

SDC provides coverage through a network of Participating Dentists. Covered Persons may access the "Find a Dentist" search tool on SDC's website (www.superiordental.com) to locate a Dentist. Contact SDC for more information about the Preferred Provider network.

XVII. YOUR PRIVACY RIGHTS UNDER HIPAA
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential information. As an

employee welfare benefit plan under ERISA, this Plan will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, Plan administration or as required or permitted by law. A description of this Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the Plan's Notice of Privacy Practices, which is furnished to all Plan participants.

XVIII. DEFINITIONS

We will use the terms and meanings shown below to determine the intent and administration of dental benefits under the Plan.

General Terms

ACTIVELY AT WORK or ACTIVE WORK

"Actively at Work" or "Active Work" mean the active expenditure of time and energy in the service of the Employer. A Participant will be deemed Actively at Work while working the full number of hours required by Employer while in a relationship with the Employer within the meaning of "employee" for federal tax withholding purposes. In addition, individuals acting as independent contractors; leased employees; consultants; temporary, free-lance, incidental, seasonal or occasional employees; individuals on retainers; or retirees are not considered Actively At Work unless each meets the requirements specified by the Employer.

CALENDAR YEAR

"Calendar Year" means the period of time from January 1, at 12:00 A.M. Midnight, through the next December 31.

CARD HOLDER

An Eligible Employee or member of the Group who has enrolled for coverage under the terms and conditions of the Plan and persons continuing coverage pursuant to COBRA or any other legally mandated continuation of coverage.

CHILD

"Child or Children" means birth children, stepchildren, legally adopted children, a child for whom you or your spouse has been ordered by a court to provide coverage or a child Placed for Adoption with you.

COBRA

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COINSURANCE

"Coinsurance" means the specific percentage of the Covered Expenses that the Covered Person will pay, after any applicable Deductible is taken.

CLAIMS ADMINISTRATOR

"Claims Administrator" means the individual or business entity, if any, appointed and retained by the Plan Administrator to supervise the management, consideration, investigation and settlement of claims, maintain records, submit reports and other such duties as may be set forth in a written agreement. If no Claims Administrator is appointed or retained or if the term is used in connection with a duty not expressly assigned to and assumed by the Claims Administrator in writing, the term will mean the Plan Administrator.

As of the Plan Effective Date, the Claims Administrator of the Plan is **Superior Dental Care, Inc**.

COVERED EXPENSES

"Covered Expenses" means expenses Incurred by a Covered Person for any necessary treatments, services or

supplies that are not specifically excluded from coverage elsewhere in the Plan, or other charges that are specifically listed as covered under the Plan.

COVERED PERSON
The term "Covered Person" means any person meeting the eligibility requirements for coverage as specified in the Plan and who is properly enrolled in the Plan. The term "Covered Person" includes Participants and Dependents.

DENTAL DISEASE or DISORDER
"Dental Disease or Disorder" means a condition that is related to the teeth, gums or the supporting tissue and bone.

DENTAL INJURY
"Dental Injury" means accidental injury only and all dental injuries sustained at one time are considered one Dental Injury. Dental Injury does not include damages to the teeth, Appliances or Prosthetic Devices that result from chewing or biting food or other substances.

DENTIST
"Dentist" means dentist, dental specialist or oral surgeon practicing within the scope of his or her license.

DENTAL HYGIENIST
"Dental Hygienist" means a person who has been trained in an accredited school; is licensed by the state in which he or she is practicing the art of dental prophylaxis; and is practicing under the direction and supervision of a Dentist.

DEPENDENT
Please see the eligibility section for definition of "Dependent."

DEPENDENT COVERAGE
"Dependent Coverage" means coverage under the Plan for benefits payable as a consequence of an illness or injury of a Dependent.

EMERGENCY
"Emergency" means a sudden and unexpected condition requiring immediate attention.

EMPLOYER
"Employer" means the Employer and any entity that is affiliated with the Employer within the meaning of Section 9.833 of the Ohio Revised Code, as amended, that adopts the Plan for the benefit of its employees, whose participation in the Plan is approved by the Employer or any duly authorized officer of the Employer. The Employer may withdraw from the Plan by delivering to the Plan Administrator written notice of its withdrawal no later than 30 days prior to the date withdrawal is to be effective.

EXPERIMENTAL
"Experimental" means the use of any procedure, treatment, facility, equipment, drug, device or supply which is not approved or accepted as standard dental treatment of the condition according to the standards set forth by the American Dental Association or any such items requiring governmental approval, if it is not granted at the time services are rendered. In determining if any treatment, procedure, facility, equipment, drug device or supply is Experimental, the Plan Administrator may consider the view of the state or national medical and dental communities and certain government financed programs. Although a Dentist or physician may have prescribed treatment, such treatment may still be considered Experimental within this definition.

The Plan Administrator, in its sole discretion, will determine whether or not a procedure, treatment, facility, equipment, drug, device or supply is Experimental or Investigative under the Plan.

FAMILY
"Family" means a covered Participant and his or her covered Dependents.

FEE MAXIMUM SCHEDULE
"Fee Maximum Schedule" means SDC's proprietary schedule of allowances for Covered Expenses based on data collected through actual and current charges throughout SDC's service area of Ohio, Kentucky, and Indiana.

FULL-TIME STUDENT
"Full-Time Student" means a Dependent Child who is enrolled in, and regularly attending, a secondary school or an accredited college, university or institution of higher learning for the minimum credit hours required by that institution in order to maintain Full-Time Student status.

GROUP
"Group" means the employer or organization who enters into an agreement with the Claims Administrators to provide administrative services for such employer's or organizations Plan.

HEALTH INFORMATION
"Health Information" means any information, whether oral or recorded in any form or medium that:

- Is created or received by the Plan, or a Plan designee; and
- Relates to any of the following:
    - The past, present or future physical or mental health or condition of an individual;
    - The provision of health care to an individual; or
    - The past, present or future payment for the provision of health care to an individual.

HIPAA
"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

INCURRED
"Incurred" means those services and supplies rendered to a Covered Person. Such expenses will be considered to have been incurred at the time or date the service or supply is actually provided, except that Incurred dates for these specific procedures are to be as follows:

A. For a crown, bridge or a cast restoration – on the first date the permanent unit is delivered/permanently cemented;
B. For root canal therapy – on the date all canals are fully obturated, filled and sealed;
C. For orthodontic appliances – on the date the service or procedure is performed or the supply is furnished

LEAVE OF ABSENCE
"Leave of Absence" means a period of time during which the Participant does not work, but which is of a stated duration after which the Participant is expected by the Employer to return to Active Work. Leave of Absence includes any period of time which is covered under the Family and Medical Leave Act (FMLA).

LIFETIME
"Lifetime" is a word used in the Plan in reference to benefit maximums and limitations. The term "Lifetime"

means the total time period of a Covered Person's coverage under the Plan, regardless of the number of breaks in that coverage. Under no circumstances does the term "Lifetime" mean the duration of a Covered Person's life.

MEDICALLY NECESSARY
"Medically Necessary' means a service, supply or treatment which, as determined by the Claims Administrator or Plan Administrator to be: (1) appropriate and consistent with the symptoms and provided for the diagnosis or treatment of your illness or injury and which could not be omitted without adversely affecting your condition or the quality of care rendered; (2) in accordance with current standards of good dental practice within the organized dental community and is medically proven to be an effective treatment of your illness or injury; and (3) the most appropriate supply or level of service that can be safely provided to you.

NAMED FIDUCIARY
"Named Fiduciary" means the individual or entity that has the ultimate authority to control and manage the overall operation of the Plan.

NON-PARTICIPATING DENTIST
"Non-Participating Dentist" means any Dentist who has not entered into an agreement with SDC to provide dental services to Covered Persons through the Preferred Provider network.

PARTICIPANT
"Participant" means a person who meets the eligibility requirements listed in this Plan and who is properly enrolled in the Plan.

PARTICIPANT CONTRIBUTION
"Participant Contribution" means that amount that is due from an eligible employee in order for that employee to obtain Participant and/or Dependent coverage(s) under the Plan. The Employer will determine the amount of the Participant Contribution that may vary depending upon the type of coverage an eligible employee desires to obtain. Eligible Participants will be advised of any required Participant Contributions at the time each applies for Participant and/or Dependent coverage. Participants in the Plan will be notified by the Plan Administrator prior to an increase in the required Participant Contribution amount. Participants in the Plan that are not required to make Participant Contributions at the time of enrollment will be notified by the Plan Administrator prior to the date a Participant Contribution requirement is made effective.

PARTICIPATING DENTIST
"Participating Dentist" means any Dentist who has entered into an agreement with SDC to provide dental services to Covered Persons through the Preferred Provider network.

PLACED FOR ADOPTION or **PLACEMENT FOR ADOPTION**
"Placed for Adoption" or "Placement for Adoption" mean the assumption and retention by such Participant hereunder of a legal obligation for total or partial support of such Child in anticipation of adoption of such Child. The Child's placement with such Participant terminates upon the termination of such legal obligation.

PLAN
"Plan" means the dental plan, as described in and administered by the Mercer-Auglaize Employee Benefit Trust.

PLAN ADMINISTRATOR
The "Plan Administrator" is the entity responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan related services.

PLAN YEAR
"Plan Year" means a period of time used for certain reporting and disclosure requirements of the Plan. The Plan Year will be the Calendar Year.

PLAN EFFECTIVE DATE
The Plan effective date is **1/1/2015**

PRECIOUS METAL
"Precious Metal" means a metal used in fillings or Crowns containing more than 50% of gold, platinum, or palladium, in any combination.

PREFERRED PROVIDER
"Preferred Provider" means a health care professional or group of professionals that have agreed to provide dental services to a group of individuals for an agreed upon fee. The Plan will specify which professionals have Preferred Provider status. A list of Preferred Providers for the Plan can be obtained from the Plan Administrator.

PROTECTED HEALTH INFORMATION (PHI)
"Protected Health Information" means Health Information that either identifies an individual, or for which there is a reasonable basis to believe can be used to identify an individual and that is one of the following:

- Transmitted by electronic media, including:
    - The internet;
    - An extranet;
    - Leased lines;
    - Dial-up lines;
    - Private networks; and
    - Those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media;
- Maintained in any electronic media; or
- Transmitted or maintained in any other form or medium.

SDC
"SDC" means **Superior Dental Care, Inc**., the Plan's Claims Administrator.

SERVICE IN THE UNIFORMED SERVICES
"Service in the Uniformed Services" means performance of duty in the Armed Forces or Uniformed Services for a period of five years or less, on a voluntary or involuntary basis, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty in the Armed Forces, the Army National Guard, Air National Guard, the commissioned corps of the Public Health Service, or any other category of persons designated by the President of the United States in time of war or emergency. Service in the Uniformed Services also includes a period for which an individual is absent from a position of employment for the purpose of an examination to determine the fitness of the person for duty in the Armed Forces or the commissioned corps of the Public Health Service.

<u>COBRA Terms</u>
If not specifically defined, all terms have the same meaning as defined in COBRA and its regulations

COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

CODE
The Internal Revenue Code of 1986, as amended.

CONTINUATION COVERAGE
The Plan coverage elected by a Qualified Beneficiary under COBRA.

QUALIFIED BENFICIARY
1) A Covered Employee whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering the Covered Employee ineligible for coverage under the Plan; and 2) A covered spouse or Dependent who becomes eligible for coverage under the Plan due to a Qualifying Event, as defined below. Qualified Beneficiary also includes any Child who is born to or Placed for Adoption with the Covered Employee during the period of Continuation Coverage.

QUALIFYING EVENT
Includes the following events that, but for Continuation Coverage, would result in the loss of coverage of a Qualified Beneficiary: 1) Termination of a Covered Employee's employment (other than gross misconduct) or reduction in the Covered Employee's hours of employment; 2) the death of the Covered Employee; 3) the divorce or legal separation of the Covered Employee from his or her spouse; 4) The Covered Employee becoming entitled to Medicare coverage; or 5) a Child ceasing to be eligible as a Dependent Child under the terms of the Plan.

TOTALLY DISABLED or TOTAL DISABILITY
Totally disabled as determined under Title II or Title XVI of the Social Security Act.

<u>Common Dental Terms</u>
ABUTMENT
A tooth or implant structure used as a support for a prosthesis.

ACID ETCH
The etching of a tooth with a mild acid to aid in the retention of composite filling material.

ACRYLIC
Plastic material used in the fabrication of dentures, crowns and as a restorative filling material.

AMALGAM
A metal alloy usually composed of mercury, silver, tin, zinc, copper and other metallic elements and used as restorative material in operative dentistry.

ANESTHESIA
Local - The condition produced by the administration of specific agents to achieve the loss of pain sensation in a specific location or area of the body. General - The condition produced by the administration of specific agents to render the patient completely unconscious and without pain sensation.

ANTERIOR TEETH
The central incisors, lateral incisors and cuspids.

APICOECTOMY
Removal of part of the tooth root.

APPLIANCE
A device used to provide function, therapeutic (healing) effect, space maintenance, or as an application of force to teeth to provide movement or growth changes as in Orthodontics. Fixed - One that is attached to the teeth by cement or by adhesive materials and cannot be removed by the patient. Removable - One that can be taken in and out of the mouth by the patient. Prosthetic - Used to provide replacement for a missing tooth.

BITEWING
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.

BRIDGEWORK, **BRIDGE** or **PROSTHETIC APPLIANCE**
Fixed - Pontics or replacement teeth retained with crowns, onlays or inlays cemented to the natural teeth, which are used as abutments. Removable - A partial denture retained by attachments that permit removal of the denture. Normally held by clasps.

CARIES
A disease of progressive destruction of the teeth from bacterially produced acids on tooth surfaces.

COMPOSITE
Tooth colored filling material primarily used in the anterior teeth.

CROWN
A natural crown is the portion of a tooth covered by enamel. An artificial crown restores the anatomy, function and esthetics of the natural crown.

DENTURE
A device replacing missing teeth. The term usually refers to full or partial dentures but it actually means any substitute for missing natural teeth.

ENDODONTIC THERAPY
Treatment of diseases of the dental pulp.

FLUORIDE
A solution of fluorine that is applied topically to the teeth for the purpose of preventing dental decay.

IMPLANT
A device surgically inserted into or onto the jawbone. It may support a crown or crowns, partial denture, complete denture or may be used as an abutment for a fixed bridge.

IMPRESSION
A negative reproduction of a given area. It is made in order to produce a positive form or cast of the recorded teeth and/or soft tissues of the mouth.

INLAY
A restoration made to fit a prepared tooth cavity and then cemented into place. Provides no cuspal coverage.

MALOCCLUSION
An abnormal contact and/or position of the opposing teeth when brought together.

OCCLUSION
The contact relationship of the upper and lower teeth when they are brought together.

ONLAY
A cast restoration that covers the entire chewing surface of the tooth and at least one cusp.

PALLIATIVE
An alleviating measure. To relieve, but not cure.

PARTIAL DENTURE
A prosthesis replacing one or more, but less than all, of the natural teeth and associated structures; may be removable or fixed, one side or two sides.

PEDODONTICS (Pediatric Dentistry)
The specialty of Children's dentistry.

PERIODONTICS
The science of examination, diagnosis, and treatment of diseases affecting the supporting structures of the teeth.

PONTIC
The part of a fixed bridge that is suspended between the abutments and that replaces a missing tooth or teeth.

POSTERIOR TEETH
The bicuspids and molars.

PROPHYLAXIS
The removal of tarter and stains from the teeth. The cleaning of the teeth by a dentist or dental hygienist.

REBASE
A process of refitting a denture by the replacement of the entire denture-base material without changing the occlusal relations of the teeth.

RELINE
To resurface the tissue-borne areas of a denture with new material.

RESTORATION
A broad term applied to any Filling, Inlay, Crown, Onlay, Bridge, Partial Dentures, or complete Denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape, form and function of part or all of a tooth or teeth.

ROOT CANAL THERAPY
The complete removal of the pulp tissues of a tooth, sterilization of the pulp chamber and root canals, and filling these spaces with a sealing material.

SCALING
The removal of calculus (tarter) and stains from teeth with special instruments.

SEALANT
A resinous agent applied to the grooves and pits of teeth to reduce decay.

SILICATE
A relatively hard and translucent restorative material that is used primarily in the anterior teeth.

SPLINTING
Stabilizing or immobilizing teeth to gain strength and/or facilitate healing.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)
A Dental Disease or Disorder involving pain and other symptoms affecting the head, jaw, and face that are caused when the jaw joints (particularly, the temporomandibular joint) and muscles controlling them do not work together correctly. TMJ disorders are sometimes referred to as myofacial pain dysfunction or syndrome, orthognathic treatment or surgery, and Costen's syndrome.

TOPICAL APPLICATION
Painting the surface of teeth, as in Fluoride Treatment or application of an anesthetic formula to the surface of the gum.

VERTICAL DIMENSION
The degree of jaw separation when the teeth are in contact.