BENEFIT BOOKLET

For the

DENTAL PLAN

Sponsored by

NORTH EAST ISD

HUMANA®
Specialty Benefits

NE ISD Ref Doc (8/10)
Elite Pref 510 w/ ortho

INTRODUCTION

This Benefit Booklet outlines the benefits, provisions and limitations of the Dental Plan sponsored by North East ISD.

If there is a conflict between the terms and/or provisions of this Benefit Booklet and the Plan Sponsor's Administrative Services Agreement, the terms and/or provisions of the Plan Sponsor's Administrative Services Agreement will supersede this Benefit Booklet.

DEFINED TERMS

A word may have a different meaning in the context of this Benefit Booklet than it does in general usage. Referring to the Definitions section as you read through this document will help *you* have a clearer understanding of this Benefit Booklet.

PRIVACY

CompBenefits understands the importance of keeping your protected health information private. Protected health information includes both medical information and individually identifiable information, such as your name, address, telephone number or Social Security number. CompBenefits is required by applicable federal law to maintain the privacy of your protected health information.

CONTACT INFORMATION

Customer Service Telephone Number:

Please refer to your CompBenefits ID card for the applicable phone number.

Claims Submittal Address:

CompBenefits Claims Office
P.O. Box 14283
Lexington, KY 40512-4283

Claims Appeal Address:

CompBenefits Claims Office
P.O. Box 14283
Lexington, KY 40512-4283

PLAN DESCRIPTION INFORMATION

1. Proper Name of Plan: North East ISD Dental Plan

2. Plan Sponsor and Employer: North East ISD
   8961 Tesoro Drive, Suite 209
   San Antonio, TX 78217
   (210) 407-0498

3. The Plan provides dental benefits for participating employees and their eligible enrolled dependents.

4. Plan benefits described in this booklet are effective January 1.

5. The Plan year is January 1 through December 31 of each year. The fiscal year is July 1 through June 30 of each year.

6. The Plan Manager is responsible for performing certain delegated administrative duties, including the processing of claims. The Plan Manager is:

   CompBenefits
   P.O. Box 14283
   Lexington, KY 40512-4283
   Telephone: (800) 342-5209

7. This is a self-funded dental benefit plan. The cost of the Plan is paid with contributions paid by the employee. Benefits under the Plan are provided from the premiums paid by employee participants and are used to fund payment of covered claims under the Plan plus administrative expenses. Please see your employer for the method of calculating contributions and the funding mechanism used for the accumulation of assets through which benefits are provided under this Plan.

8. Each employee of the employer who participates in the Plan receives a Benefit Booklet. The Benefit Booklet will be provided to employees by the employer. It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other Plan information.

9. The Plan benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the employer. Significant changes to the Plan, including termination, will be communicated to participants as required by applicable law.

10. Upon termination of the Plan, the rights of the participants to benefits are limited to claims incurred and payable by the Plan up to the date of termination.

11. The Plan does not constitute a contract between the employer and any covered person and will not be considered as an inducement or condition of the employment of any employee. Nothing in the Plan will give any employee the right to be retained in the service of the employer, or for the employer to discharge any employee at any time.

12. This Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation coverage.

DEFINITIONS

You will need to know what is meant by certain terms used in this booklet. They are defined below.

“You” and “Your” mean the employee.

“We”, “Our” and “Us” mean CompBenefits, The Plan Manager.

“Premium Due Date” is the month prior to the first day of each calendar month.

“Effective Date” means the date the Plan begins.

“Eligibility Date” means the date the employee can become covered as defined under When You Can Be Covered.

"Benefit Year" is January 1 through December 31 of each year.

"Covered Dental Expenses" means the kinds of expenses which can apply to meet the Deductible or for which Dental Benefits can be paid. Covered Dental Expenses include only certain charges for services or supplies which do not exceed the Reimbursement Rate when ordered by a dentist for dental care and treatment. The charges for services or supplies listed in the Schedule of Benefits are the only charges that are Covered Dental Expenses.

"Covered Dental Injury" means all damage to a covered person's mouth due to an accident caused by any sudden, unexpected impact from outside the oral cavity, and all complications arising from that damage.

"Deductible" means the dollar amount of Covered Dental Expenses that must be incurred and paid by you before benefits can be paid. The Deductible is applied chronologically by the dates on which CompBenefits receives claims for Covered Dental Expenses. If all or any portion of an covered's or member's Deductible for a calendar year is applied against Covered Dental Expenses incurred by an covered or member during the last three months of the contract period, the covered's or member's Deductible for the next ensuing contract period shall be reduced by the amount so applied.

"Dental Treatment Plan" means a dentist's report, on a form that meets Our approval, which: (a) itemizes the dental procedures that the dentist will perform; (b) lists the charges for each procedure; and (c) is accompanied by supporting pre-operative x-rays and any other appropriate diagnostic material required by Us. Related procedures (such as cleaning, root planing, fillings and crowns) will be considered part of the same Dental Treatment Plan even if reported on different claim forms and/or on different dates of service, if they are performed within four months of one another.

"Dentist" means any dental or medical practitioner who: a) is properly licensed or certified under the laws of the state where he practices; and b) provides services which are within the scope of that license or certificate.

“Group**”** means the aggregate of individuals eligible to be covered under this Benefit Booklet.

"Participating Dentists Fee Schedule" is a schedule of maximum allowable charges that participating network Dentists have agreed to use when charging You or Your Dependent.

“Reimbursement Rate” means the total dollar amount of reimbursement for a Covered Dental Expense as determined by combining actual charges and relative values of the services in the area. Factors considered when determining Reimbursement Rate include geographic area and actual billed rates for services provided.

BECOMING COVERED

Who Can Be Covered

All persons who are members of the Group can be covered. You are a member of the Group if:
1. You are an eligible employee (defined by the Plan Sponsor); and
2. You work at least the minimum number of hours per week (defined by the Plan Sponsor).

If You and Your spouse are members of the Group, either of You may choose to be covered for Dental Benefits:
1. as an employee; or
2. as a dependent.
   If one chooses to be covered as a dependent, the other must choose to be covered as an employee.

When You Can Be Covered

You can be covered on the Effective Date if:
1. You are a member of the Group on that date; and
2. You have completed the initial waiting period, as shown in the Schedule of Benefits.

If You do not meet the above requirements on Effective Date, Your Eligibility Date will be the next open enrollment period as may be determined and approved by the Plan Sponsor.

When Your Coverage Begins

You must enroll within 31 days of your Eligibility Date. If You enroll and You meet the Actively At Work Requirement, Your coverage will begin at 12:01 a.m. on the first day of the month following your Date of Hire which is the same as or which next follows the date You enroll.

If You do not enroll within 31 days of Your Eligibility Date, You may not enroll until the next open enrollment period as may be determined and approved by the Plan Sponsor.

Actively At Work Requirement

You must be actively at work to become covered under the Plan. To be actively at work, You must:

1. be able to do the normal tasks of Your job on a full-time or part-time basis for a full work day on the day Your coverage is to begin;
2. be able to do such tasks at one of Your employer's normal places of business or at a location to which You must travel to do Your job; and
3. not be absent from work because of leave of absence or temporary lay-off.

If You do not meet the above requirements, coverage will begin on the first of the following month which is the same as or next follows the day on which You do meet these requirements.

Coverage For Your Dependents

If You are covered under the Plan, You can also cover Your Eligible Dependents. If You and Your spouse are members of the Group, either of You - but not both - may cover Your children who are Eligible Dependents.

Who Are Your Eligible Dependents

Your Eligible Dependents are:

1. Your spouse, if You are legally married; and
2. Your children who are:
   - (a) up to the Dependent Age listed in the Schedule of Benefits; or
   - (b) up to the Dependent Maximum Age listed in the Schedule of Benefits; or
   - (c) are not capable of self-support due to a mental or physical handicap, subject to the following conditions:
     - (1) the child must have become incapable prior to his or her 26th birthday, and must be covered as Your Eligible Dependent when he/she reaches age 26;
     - (2) You must give CompBenefits written proof that the child is incapable; and
     - (3) You may be required to give proof at a later date that the child is still incapable, but not more than once each year after two years following the first proof.

A "child" also includes adopted children, stepchildren, children placed in court-ordered custody, including foster children.

For purposes of this Plan the following are excluded from coverage: 1) a dependent child who can be covered as a member of the Group; or 2) a dependent who is on active duty with the armed forces of any country.

Coverage For Children Placed For Adoption

A child placed with You for adoption will be an Eligible Dependent for Dental coverage. Dental coverage for that child will begin on the earlier of: 1) the date of birth if a petition for adoption is filed within 31 days of the birth of such child; or 2) the date You gain custody of the child under a temporary court order that grants You conservatorship of the child; or 3) the date the child is placed with You for adoption; and additional premium, if any, is paid within 31 days of such date.

When Coverage For Dependents Begins

If you have Eligible Dependents on the day you first become covered, You can enroll for them on that day. If You do not have Eligible Dependents on the day You first become covered, but later acquire an Eligible Dependent, You can enroll them within 31 days from the date they become Eligible Dependents. In the event of marriage, Your spouse's coverage will begin the first day of the first calendar month beginning after the date the Plan Sponsor receives the request for enrollment. For other Eligible Dependents, Your dependent's coverage will begin on the date they become an Eligible Dependent. If you do not enroll your Eligible Dependent(s) within 31 days of their eligibility, You may not enroll for them until the next open enrollment period as may be determined by the Plan Sponsor.

A child born to You while You are covered will be an Eligible Dependent and will automatically be covered for 31 days following the moment of birth. If You choose to cover Your newborn, You must enroll the child within 31 days of his date of birth or coverage for that child will terminate at the end of the 31-day period.

When Your Coverage Ends

Your coverage will end at 12:01 a.m. on the earliest of:

1. The date on which the Plan terminates.
2. The last day of the month which follows Your last payment to the cost of Your coverage if You stop Your payments.
3. The last day of the month which follows the date You are no longer a member of the Group.
4. The last day of the month in which Your employment terminates.
5. The day you enter into any naval, military, air force or any other armed service in any country.

When Your Dependents' Coverage Ends

Coverage for Your dependents will end at 12:01 a.m. on the earliest of:

1. the date the Group Plan ends;
2. the date the Group Plan is changed to exclude coverage for Your dependents;
3. the date Your coverage ends; or
4. the date ending the term that coverage is in force because of Your last payment to the cost of coverage for Your dependents if You stop Your payments.

Coverage for any one dependent will end on the last day of the month in which he ceases to be an Eligible Dependent.

DENTAL BENEFITS

The Dental Benefits described on the pages that follow apply to Covered Dental Expenses incurred:

1. by You while You are covered; and
2. for a dependent while You are covered for the dependent.

Benefits will be paid after Covered Dental Expenses during a Benefit Year exceed the Deductible. Covered Dental Expenses will include only those charges for treatment or services that begin and are completed while You and Your dependents are covered.

Beginning Date for Treatment or Service

For benefit determination purposes, the following will define the date on which certain Covered Dental Expenses will begin:

1. for full dentures or partial dentures - on the date the final impression is made;
2. for fixed bridges (including a resin bonded bridge), crowns, inlays, onlays and other laboratory prepared restorations - on the date final preparation of the teeth is completed;
3. for root canal therapy - on the date the pulp chamber is first opened;
4. for periodontal surgery - on the date the surgery is actually performed; and
5. for all other services - on the date the service is performed.

The Plan will not pay benefits for any service which started prior to the patient being covered. If a procedure is started before the expiration of the waiting period to which that procedure is subject, no benefit will be payable, even if the procedure is completed after the expiration of the waiting period.

Completion Date for Treatment or Service

For benefit determination purposes, the following will define the date on which certain Covered Dental Expenses will be completed:

1. for dentures and partial dentures - on the date the final completed appliance is inserted in the mouth. However, no denture or partial denture will be considered completed unless and until it is accepted by the patient; and
2. for fixed bridges (including a resin bonded bridge), crowns, inlays, onlays, and other laboratory prepared restorations - on the date that the appliance is permanently cemented in place; for all other services, on the date the service is performed.
3. for root canal therapy - on the date the canals are permanently filled;
4. for periodontal surgery - on the date the surgery is actually performed; and
5. for all other services - on the date the service is performed.

Waiting Periods

Benefits for certain services are payable only after a person has satisfied a waiting period. Waiting periods are identified in the Schedule of Benefits.

Benefits Payable

Based on your Plan design, Benefits are payable at either a) the lesser of the Reimbursement Rates or actual charges incurred by You or Your dependents for Covered Dental Expenses, or b) the lesser of the Scheduled Benefits or actual charges incurred by You or Your dependents for Covered Dental Expenses. To receive benefits, the expenses incurred must exceed the Deductible. The expenses used to meet the Deductible must be incurred within a Benefit Year. When the Deductible is met, the Plan will pay benefits for expenses incurred during the rest of the Benefit Year. The amount of the benefits will be

equal to the covered percentage of the Covered Dental Expenses or the Scheduled Benefits for the Covered Dental Expenses that are more than the Deductible. The covered percentages or Scheduled Benefits that apply to Covered Dental Expenses are shown in the Schedule of Benefits. No benefits are payable for expenses listed in the section headed "Exclusions". The maximum benefit which will be paid is explained in the section headed "Maximum Benefits".

Estimate of Benefits

If Covered Dental Expenses for a procedure are expected to be more than $300, the Plan recommends You send to Us a Dental Treatment Plan for the procedure before treatment begins. The Dental Treatment Plan should be accompanied by supporting pre-operative x-rays and any other appropriate diagnostic materials as requested by Us. We will notify You and Your dentist of the benefits payable based upon the Dental Treatment Plan. In determining the amount of benefits payable, consideration will be given to alternate procedures that may accomplish a professionally satisfactory result. If You and Your dentist decide on a more expensive method of treatment, the Plan will not pay the excess amount. The maximum Covered Dental Expense to be considered for payment will be the most economical procedure, determined by the Plan, to accomplish a professionally satisfactory result.

Maximum Benefits

The total amount of Dental Benefits that will be paid for one person for expenses (other than orthodontic expenses) incurred in a Benefit Year will not be more than the Maximum Annual Payment shown in the Schedule of Benefits.

Orthodontic Benefits

The total amount of Dental Benefits that will be paid for orthodontic treatment and appliances, incurred in any Benefit Year, will not be more than the Orthodontic Annual Maximum if an Orthodontic Annual Maximum is shown in the Schedule of Benefits. The total amount of Dental Benefits that will be paid for orthodontic treatment and appliances during the entire time covered will not be more than the Orthodontic Lifetime Maximum shown in the Schedule of Benefits. Orthodontic treatment will begin on the date the bands or appliance(s) are first inserted. Any other treatment that can be completed on the same day as performed will be considered started and completed on the actual date that the treatment is performed.

Orthodontic benefits are paid in equal quarterly installments over the course of the entire Dental Treatment Plan. The benefit payment schedule will be calculated by:

1. determining the total benefit payable for the orthodontic treatment plan;
2. defining the amount of the initial payment as 25% of the total benefit; and
3. divide the 75% balance of the total benefit by the number of quarters that the orthodontic treatment will continue to determine the amount which will be paid for each subsequent quarter of treatment.

The first installment will be payable as of the date on which the orthodontic appliances are first installed. The subsequent quarterly benefit payments will be made for as long as the coverage remains in force provided that You submit proof to Us that treatment continues.

Major Restorative Limitations

The charges for Major Restorative services will be Covered Dental Expenses subject to the following:

1. a denture, partial denture, or fixed bridge (including a resin bonded fixed bridge) must replace a Natural Tooth extracted while covered for Dental Benefits under this Plan, however, this provision will not apply if the Plan replaces a prior Plan You had with another insurer and You are covered by this Plan on its Effective Date without a break in coverage provided: a) the prosthetic replaces teeth that were extracted while covered under the prior Plan; and b) the prosthetic work is completed within 12 months of the extraction;
2. the replacement of a partial denture, full denture, or fixed partial denture (including a resin bonded bridge), or the addition of teeth to a partial denture if: (a) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (b) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (c) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a Functioning Natural Tooth while covered for Dental Benefits under this Plan; or (d) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;
3. the replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations if: (a) replacement occurs at least five years after the initial date of insertion; and (b) they are not serviceable and cannot be restored to function;
4. the replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition; and
5. the replacement of teeth up to the normal complement of 32.

Exclusions

Benefits will not be paid for:

1. procedures which are not included in the Schedule of Benefits; which are not medically necessary; which do not have uniform professional endorsement; are experimental or investigational in nature; for which the patient has no legal obligation to pay; or for which a charge would not have been made in the absence of coverage;
2. any procedure, service, or supply which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by the Plan;
3. crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;
4. appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting;
5. any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite registration, or bite analysis;
6. pulp caps, adult fluoride treatments, athletic mouthguards; myofunctional therapy; infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery; completion of claim forms; exams required by third party; personal supplies (e.g. water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
7. charges for travel time; transportation costs; or professional advice given on the phone;
8. procedures performed by a Dentist who is a member of Your immediate family;
9. any charges, including ancillary charges, made by a hospital, ambulatory surgical center, or similar facility;
10. charges for treatment rendered: (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any member of Your family; or (b) by an employee of the employer of any member of Your family;
11. any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;
12. charges for treatment performed outside of the United States other than for emergency treatment. Benefits for emergency treatment which is performed outside of the United States are limited to a maximum of $100 (US dollars) per year;
13. the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;
14. treatment for cosmetic purposes - facings on crowns or bridge units on molar teeth will always be considered cosmetic;
15. any services or supplies which do not meet the standards set by the American Dental Association or which are not reasonably necessary, or customarily used, for dental care;
16. procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an covered basis;
17. an injury that arises out of or in the course of a job or employment for pay or profit for which benefits are available under any workers' compensation act or similar law; or
18. charges to the extent that they are more than the Reimbursement Rate. If the amount of the Reimbursement Rate for a service cannot be determined due to the unusual nature of the service, the Plan will determine the amount. The Plan will take into account: (a) the complexity involved; (b) the degree of professional skill required; and (c) other pertinent factors.

COORDINATION WITH OTHER BENEFITS

1. APPLICABILITY.

This Coordination With Other Benefits provision applies to This Plan when You or Your covered dependents have dental care coverage under more than one Plan. "Plan" and "This Plan" are defined below. If this provision applies, the Order of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

(a) will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another Plan; but
(b) may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in Section 4, Effect on the Benefits of This Plan.

2. DEFINITIONS.

A "Plan" is any group coverage or group type coverage, whether covered or uncovered, which provides benefits for, or because of, dental care or treatment. This also includes 1) group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans; 2) group coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans or self covered employee benefit plans; and 3) medical benefits coverage in group, group type, and individual automobile "no-fault" type contracts or group or group-type automobile "fault" contracts. It does not include school accident type coverages, coverage under any governmental plan required or provided by law, or any state plan under Medicaid. Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and coordination applies only to one of the two, each of the parts is a separate Plan.

"This Plan" is the part of the Group Plan that provides Dental Benefits.

"Primary Plan"/"Secondary Plan". The Order of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

"Allowable Expenses" means a necessary, reasonable and customary item of expense for dental care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

"Claim Determination Period" means a Benefit Year. However it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this provision or a similar provision takes effect.

3. ORDER OF BENEFIT DETERMINATION RULES.

This Plan determines its order of benefits using the first of the following rules which applies:

(a) The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, 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, then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent. Except in the case of legal separation or divorce (further described below), when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":
   (1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
   (2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
   However, if the other Plan does not have the rule described immediately above, and if, as a result, the Plans do not agree on the Order of Benefits, the rule in the other Plan will determine the order of benefits.

(b) If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   (1) first, the Plan of the parent with custody of the child;
   (2) then, the Plan of the spouse of the parent with custody of the child; and
   (3) finally, the Plan of the parent not having custody of the child.
   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(c) The benefits of a Plan which covers a person as an employee who is neither laid off, retired or continuing coverage under a right of continuation (or as a dependent of the person) are determined before those of a Plan which covers that person as a laid off, retired or continuing coverage (or as a dependent of that person). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the Order of Benefits, this rule is ignored.

(d) If none of the above rules determines the Order of Benefits, the benefits of the Plan which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

4. EFFECT ON THE BENEFITS OF THIS PLAN.

This section applies when, in accordance with Section 3. Order of Benefit Determination Rules, This Plan is a Secondary Plan to one or more other Plans. In the event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the Other Plans". The benefits of This Plan will be reduced when the sum of:

(a) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this provision; and
(b) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this provision, whether or not claim is made;

exceeds those Allowable in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

5. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these rules. CompBenefits has the right to decide which facts are needed. CompBenefits may get needed facts from, or give them to, any other organization or person. CompBenefits need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give CompBenefits any facts deemed necessary to pay the claim.

6. FACILITY OF PAYMENT.

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, CompBenefits may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. CompBenefits 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 reasonable cash value of the benefits provided in the form of services.

7. OVERPAYMENTS.

If the amount of the payments made by CompBenefits are more than should have paid under this provision, CompBenefits may recover the excess from one or more of: (a) the persons for whom payment has been made; (b) coverage companies or other organizations providing benefits under another Plan.

NOTICE OF CONTINUATION OF GROUP DENTAL COVERAGE RIGHTS (COBRA)

If You are member of an employer Group with 20 or more employees and Your coverage terminates in accordance with the other terms of the Plan, You may elect to continue the coverage in force as described in this section. You may elect to continue coverage if You are currently covered under the Plan, and if such coverage is terminating due to any of the following Qualified Events:

1) Termination of Your employment (for reasons other than gross misconduct).
2) Reduction of work hours including lay-off.
3) Death of the covered person.
4) Divorce or legal separation.
5) A child ceases to be a dependent as defined in this Plan.
6) The Plan files for a Chapter 11 bankruptcy petition, and as a result to this You suffer a loss of coverage under Your retiree coverage.

However, no continuation of coverage will be provided if You are covered under another group dental care plan coincident with or prior to any of the above events occurring. Continuation of coverage will be retroactive to the date of termination.

The maximum continuation of coverage period with respect to a reason described above is:

1) 18 months with respect to 1 or 2 above. If You are disabled as determined under Title II or XVI of the Social Security Act, then You and any other non-disabled eligible individuals will be eligible for an additional 11 months.
2) 36 months with respect to 3, 4 or 5 above.
3) With respect to 6 above, lifetime coverage for You, whereas Your Eligible Dependents will be covered until the earlier of a) Your death; or, b) Death of the Eligible Dependent.

If, while coverage is being continued, further events occur which would entitle You to again elect continuation, the total period of continuation may not exceed 36 months from the date the initial continuation commenced, other than the coverage due to bankruptcy filing as described above.

It is Your responsibility to notify the Plan of the occurrence of a Qualifying Event other than termination of employment or reduction in work hours. You must notify the Plan within 60 days. It is the responsibility of the Plan to provide You with written notice of Your right to continue coverage under this Section. Such notice will also contain the amount of monthly premium You must pay to continue coverage and the time and manner in which such payments must be made.

To continue coverage under this Plan You must notify the Plan of Your election within 60 days of the latest of: a) the date of the Qualifying Event; b) the date of the loss of coverage; or c) the date the Plan sends notice of the right to continue coverage.

Payment for the cost of coverage for the period preceding the election must be made to the Plan within 45 days after the date of such election. Subsequent payments are to be made to the Plan in the manner described by the Plan in the notice.

Continuation of coverage will terminate at the earliest of the following dates: 1) The end of the maximum continuation of coverage period; 2) The last day of the period of coverage for which premiums have been paid, if You fail to make a premium payment when due; 3) Your becoming covered under another group dental care plan as an employee, spouse or dependent child; however, coverage will continue for a pre-existing condition for which treatment has already commenced and which is excluded or limited by the other group dental plan; 4) Discontinuance of this Dental Care Benefit Provision; 5) The date Your employer ceases to provide any group dental plan.

GENERAL PROVISIONS

Legal Action

No legal action shall be brought to recover on a claim prior to the end of 60 days after proof of loss has been filed. No such action shall be brought at all unless brought within six years from the end of the time in which proof of loss is required.

Participating Provider Network

Participating dentists have agreed to charge You or Your eligible Dependents based on a Participating Dentists Fee Schedule. Benefits payable to non-participating dentists may be based on either the Reimbursement Rate or the Participating Dentists Fee Schedule. Non-participating dentists may bill You for the balance of their charges. Please check Your Schedule of Benefits to determine if Your plan features a participating network option. If it does, please refer to the list of participating network Dentists prior to making an appointment.

Submitting A Claim

This section describes what You (or You authorized representative) must do to file a claim for Plan benefits.

- A claim must be filed with the Plan Manager in writing and delivered to the Plan Manager, by mail, postage prepaid..

- Claims must be submitted to the Plan Manager at the address indicated in the documents describing the Plan or claimant's identification card. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.

- Also, claims submissions must be in a format acceptable to the Plan Manager and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by the Plan.

- Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than one year after the date of loss, except if you were legally incapacitated. Plan benefits are only available for claims that are incurred by a covered person during the period that he or she is covered under the Plan.

- Claims submissions must be complete. They must contain, at a minimum:

    - The name of the covered person who incurred the covered expense;
    - The name and address of the dental provider;
    - The diagnosis of the condition;
    - The procedure or nature of the treatment;
    - The date of and place where the procedure or treatment has been or will be provided;
    - The amount billed and the amount of the covered expense not paid through coverage other than Plan coverage, as appropriate;
    - Evidence that substantiates the nature, amount, and timeliness of each covered expense in a format that is acceptable according to industry standards and in compliance with applicable law.

A general request for an interpretation of Plan provisions will not be considered to be a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the Plan, should be directed to the Plan Administrator.

Dental claims and correspondence should be mailed to:

CompBenefits Claims Office
P.O. Box 14283
Lexington, KY 40512-4283

SCHEDULE OF BENEFITS

Indemnity Plan

Waiting Period for Type I Services:	**None**
Waiting Period for Type II Services:	**None**
Waiting Period for Type III Services:	**12 months**
Waiting Period for Type IV Services:	**12 months**

Dependent Age:	**up to 26**
Dependent Maximum Age:	**up to 26**
Annual Deductible:	**$50 per person, max 3 per family, waived for Type I**

	Year 1	Year 2	Year 3
Type I – Diagnostic and Preventive Services	**100%**	**100%**	**100%**
Type II – Basic Restorative Services	**40%**	**60%**	**80%**
Type III – Major Services	**none**	**30%**	**50%**
Maximum Annual Benefit	**$750**	**$1,250**	**$1,750**
Type IV – Orthodontia	**none**	**25%**	**50%**

Orthodontic Annual Maximum: $1,000
Orthodontic Lifetime Maximum: $2,000

Orthodontic care will be provided when in the opinion of the Orthodontic Consultant a satisfactory result can be achieved. Cross bite in permanent teeth will only be treated when, in the opinion of the Orthodontic Consultant, other conditions are present which would indicate that orthodontic treatment is necessary. Plan benefits shall cover 24 months of usual and customary Orthodontic Care. Treatment beyond said 24 months will not be covered.

Type A Covered Expenses - Preventive and Diagnostic

Charges for the following treatments, services and supplies are deemed Type A Covered Expenses, provided the above conditions are met:

- Periodic oral examinations, routine and Periodontic prophylaxes including cleaning, scaling and polishing, twice a year during the plan year.
- X-Ray services including:
    - full mouth x-rays once in any (36) consecutive month period;
    - bitewing x-rays including examination, twice a year during the plan year; and
    - single film x-rays.

- Topical application of fluoride for Covered Person under (19) years of age, once in any (12) consecutive month period.
- Sealant applications for Covered Persons under (14) years of age, once in any (12) consecutive month period.
- Space maintainers and non-orthodontic corrective appliances for Covered Persons under (16) years of age (initial appliances only).
- Emergency palliative (pain relieving) examination and treatment not otherwise included as a Covered Expense.

Type B Covered Expenses - Basic Restorative and Corrective

Charges for the following examinations, treatments, services and supplies are deemed Type B Covered Expenses, provided the above conditions are met:

- Amalgam, silicate, plastic, acrylic or composite restorations (fillings) of primary or permanent teeth.
- Adjustments to fixed bridges and dentures including:
    - relining and rebasing of dentures, once in any (12) consecutive month period;
    - reattachment of damaged or broken clasps; and
    - adjustment to a denture more than six months after installation.
- Oral Surgery including:
    - simple extractions;
    - surgical removal of erupted teeth involving tissue flap and bone removal; and
    - removal of impacted teeth.
- Anesthesia, if medically necessary, in conjunction with surgical procedure.
- Periodontic services (treatment of the gums) including gingival curettage, osseous surgery and periodontal scaling and planning.

Type C Covered Expenses - Major Restorative and Corrective

Charges for the following treatments, services and supplies are deemed Type C Covered Expenses, provided the above conditions are met:

- Endodontic procedures including:
    - root canal therapy;
    - pulp capping; and
    - vital pulpotomy.

- Inlays and onlays involving single or multiple surfaces.

- Crowns and posts including:
    - acrylic and acrylic processed to metal;
    - porcelain and porcelain fused to metal;
    - metal full cast; and
    - gold full cast.

- Installation of Prosthodontic including:
    - complete upper dentures;
    - complete lower dentures;
    - partial dentures having acrylic base with two clasps;
    - repairs to dentures including broken teeth;
    - fixed bridges including cast metal, porcelain fused to metal and plastic processed to metal;
    - simple stress breakers; and
    - addition of teeth to partial dentures to replace extracted natural teeth.

The provision of an initial prosthodontic appliance (i.e. fixed bridge restoration, removable partial or complete denture, etc.) will be deemed a Covered Expense only if such appliance is required because at least one additional natural tooth was necessarily extracted after the date the person became covered.

The replacement of an existing prosthodontic device will be deemed a Covered Expense only if one (or more) of the following conditions are met:

- The replacement appliance is required because at least one natural tooth was necessarily extracted after the date the person became covered and if the existing appliance could not have been made serviceable. If the existing appliance could have been made serviceable, only the expense for that portion of the replacement appliance which replaces the teeth extracted after the person became covered shall be covered.

- The replacement appliance replaces an existing appliance, which is at least five years old and cannot be made serviceable.

- The replacement appliance replaces an existing appliance, which was temporarily installed after the date the person became covered. In this event, the first such replacement appliance shall be considered a permanent installation.

- The replacement appliance is required as a result of the installation of an initial opposing denture after the date the person became covered.

- The replacement appliance is required as the result of accidental bodily injury, which occurred after the date the individual became covered.

Type D Covered Expenses - Orthodontia

Subject to the Deductible, Waiting Period and Maximum Benefit provisions, if Covered Expenses are incurred for orthodontic care and services, the Plan will pay benefits up to 50% of the lesser of:

- the Covered Expenses actually incurred; or
- the Usual, Customary and Reasonable Charges for such services.

Orthodontic Care and Services includes:

- comprehensive full-banded treatment and fixed or cemented appliances for tooth guidance; and
- correction of malocclusion of jaws or other teeth irregularities by mechanical means.

Waiting Period

The Waiting Period is the period of time between the date a Person is first covered and the date benefits become payable with respect to any loss or expense incurred thereafter. The Waiting Period for orthodontic benefits is (12) months.

Deductible

Any deductible requirements under the Plan must be met before benefits are payable. Expenses for Orthodontic Care and Services incurred after the Waiting Period has been satisfied will be applied to meet the deductible requirement.

Orthodontic Annual and Maximum Lifetime Benefit

The Maximum Benefit payable each calendar year per Covered Person shall be the amount shown in the Schedule of Benefits. The Maximum Lifetime Benefits per Covered Person shall be $2,000.00.

Method of Benefit Payment

The first payment will be payable as of the date the orthodontic appliance is first installed. Additional benefits will be payable as services are rendered according to the initial treatment plan, provided:

- treatment is continuous; and
- coverage remains in force;

and payments are subject to any Waiting Period, Deductible, Annual Benefit and Maximum Lifetime Benefit provisions. Benefits will be payable only if the orthodontic appliance is installed while the child is covered under this Plan. Such benefits are in addition to any other benefits payable under the Plan.

PRE-DETERMINATION OF BENEFITS

If the cost of planned dental treatment or supplies can reasonably be expected to exceed $300.00, the Claims Administrator will pre-determine the benefits payable upon request. The Covered Person should instruct the dentist to submit a written treatment plan, with supporting x-rays and any other documentation necessary to support the dental necessity of proposed treatment to the Claims Administrator, and the charge for each service. This, of course, is not necessary for emergency treatment. The Claims Administrator will then inform the dentist and Covered Person of the amount payable for the proposed treatment before it begins.

If a description of the procedures to be performed, x-rays and an 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.

Pre-determination of benefits does not guarantee payment. Benefits actually paid will be based on the benefits, if any, for which the Covered Person qualifies at the time the treatment or service is rendered.

HIPAA PRIVACY

HIPAA Privacy: This section became effective April 14, 2004. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA" protects the privacy of certain types of individual health information and regulates the use of such information by the Plan. The Department of Health and Human Services has issued regulations at 45 CFR Parts 160 and 164 ("Privacy Regulations"). The individual health information that is protected ("Protected Health Information" or "PHI") is any information created or received by the Plan that relates to (1) a Covered Person's past, present or future physical or mental health or past, present or future physical or mental condition; (2) the provision of dental care to a Covered Person; or (3) the past, present, or future payment for a Covered Person's dental care.

However, HIPAA allows dental information, including PHI, to be disclosed by the Plan to the Plan Sponsor and to be used by the Plan Sponsor. The permitted disclosures to and uses by the Plan Sponsor of health information are as follows:

- The Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary information for the purpose of (1) obtaining bids for providing insurance coverage; or (2) modifying, amending, or terminating the Plan. The Plan Sponsor may use summary information so received from the Plan only for these two listed purposes.

- The Plan may disclose to the Plan Sponsor, and the Plan Sponsor may use, information on whether an individual is participating in the Plan or is enrolling or disenrolling in the Plan.

- The Plan may disclose PHI to the Plan Sponsor and/or the Plan Sponsor may use such PHI if a Participant has specifically authorized in writing such disclosure and/or use.

- The Plan may disclose PHI to the Plan Sponsor, and the Plan Sponsor may use PHI, to carry out Plan administration functions, such as activities relating to:

    - obtaining contributions or determining or fulfilling responsibility for coverage and provision of benefits under the Plan;

    - payment for or obtaining or providing reimbursement for dental care services. Payments under the Plan generally are made to the Dental Practioner. All Covered Persons are hereby notified and should be aware that the Plan and the Plan Sponsor will be providing PHI concerning all Dependents of a Participant to that Participant as part of the Explanation of Benefits;

    - determining eligibility for, or eligibility for one or more types of coverage or benefits provided under, the Plan;

    - coordination of benefits or other cost-sharing mechanisms;

- adjudication and subrogation of claims, billing, claims management, collection activities and related dental care data processing;

- review of dental care services with respect to coverage under the Plan or justification of charges;

- disclosure to consumer reporting agencies of any of the following PHI regarding collection of contributions or reimbursement: name and address, date of birth, Social Security Number, payment history, account number and name and address of the Plan;

- dental review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

- business planning and development, such as conducting cost-management and planning-related analyses relating to managing and operating the Plan;

- resolution of internal grievances;

- prosecution or defense of administrative claims or lawsuits involving the Plan or Plan Sponsor;

- conducting quality assurance and improvement activities, case management and care coordination;

- evaluating dental care provider performance or Plan performance; and

- contacting dental care providers and patients with information about treatment alternatives.

- These uses and disclosures are consistent with the Privacy Regulations.

Agreement by Plan Sponsor: This section shall become effective April 14, 2004. The Plan Sponsor has agreed to (and the Plan has received a certification from the Plan Sponsor evidencing such agreement) the following restrictions:

- The Plan Sponsor will not use or further disclose the PHI except (1) as described above or (2) as otherwise required by law.

- Any agents or subcontractors of the Plan Sponsor to whom the Plan Sponsor provides PHI will agree to the same restrictions and conditions on the use and disclosure of PHI that apply to the Plan Sponsor.

- The Plan Sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other non-health benefit or non-health employee benefit plans of the Plan Sponsor.

- The Plan Sponsor will report to the Plan any use or disclosure of the PHI that is inconsistent with the permitted uses and disclosures of which the Plan Sponsor becomes aware.

- The Plan Sponsor will give Participants access and provide copies to them of their PHI in accordance with the HIPAA Privacy Regulations.

- The Plan Sponsor will allow Participants to amend their PHI in accordance with the HIPAA Privacy Regulations.

- The Plan Sponsor will make available PHI in order to make an accounting of PHI in accordance with the HIPAA Privacy Regulations.

- The Plan Sponsor will make available its internal practices, books and records relating to the use and disclosure of PHI received from the Plan to the Secretary of Health and Human Services (or the Secretary's designee) for determining compliance by the Plan with the HIPAA Privacy Regulations.

- The Plan Sponsor will, if feasible, return or destroy all protected PHI received from the Plan and retain no copies of the PHI when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, if will limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

The Plan has issued a Privacy Notice which explains the Plan's privacy practices and individuals' rights under HIPAA. This Privacy Notice is available by contacting the Plan's Privacy Officer at the following address: Employee Benefits Manager, North East ISD, 8961 Tesoro Drive, Suite 209, San Antonio, Texas 78217.