COUNTY OF DU PAGE

Your Dental Care Benefit Program

A message from

COUNTY OF DU PAGE

This booklet describes the Dental Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your dental care claims, we have engaged CompDent as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your dental care benefits. If you want more information or have any questions about your dental care benefits please contact the Employee Benefits Department.

Sincerely,
COUNTY OF DU PAGE

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BENEFIT HIGHLIGHTS

Your dental care benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire benefit booklet.

DENTAL BENEFITS

Deductible	$50 per benefit period
Preventive Services Benefit Payment Level	100% of the U&C Fee*
Primary Services Benefit Payment Level	80% of the U&C Fee*
Major Services Benefit Payment Level	50% of the U&C Fee*
Benefit Period Maximum	$1,500
Orthodontic Services Deductible	$50 per lifetime
Orthodontic Services Benefit Payment Level	50% of the U&C Fee*
Orthodontics Lifetime Maximum	$1,000

*Usual and Customary Fee

County of DuPage PPO plan:

By using one of the CompBenefits PPO providers you have the benefit of reduced out-of-pocket expenses. You also get additional peace of mind knowing that our providers go through an extensive credentialing process. You still have the option of going out-of-network and using any licensed dentist for treatment. The plan reimburses a greater percentage of eligible expenses if you go in-network than if you go out-of-network. The provider directory (separate booklet) lists all in-network dentists in the PPO plan. Members can choose any of the dentists in the directory and do not need to notify Member Services upon changing dentists. Our toll-free customer service number at (800) 342-5209 has Member Services Representatives who can provide the answers you need quickly and thoroughly.

The benefits of using the CompBenefits PPO network include:

- Negotiated contracts with providers to allow members to receive savings
- No usual and customary fees (bills paid to a set fee schedule)
- Lower out of pocket expenses
- Approximately 70 in-network dentists in DuPage county

The out of network option in the PPO is identical to the Indemnity plan. There are additional savings if employees use a dentist listed in the provider directory.

DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your dental care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

CLAIM..... means notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR..... means CompDent.

CLAIM CHARGE..... means the amount which appears on a Claim as the Provider's charge for service rendered to you.

CLAIM PAYMENT..... means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you.

COURSE OF TREATMENT..... means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE..... means the date on which your coverage under the Health Care Plan begins.

COVERED SERVICE..... means a service and supply specified in this benefit booklet for which benefits will be provided.

DENTIST..... means a duly licensed dentist.

ELIGIBLE PERSON..... means an employee of the Employer who meets the eligibility requirements for this health coverage, as described in the ELIGIBILITY SECTION of this benefit booklet.

EMPLOYER..... means the company with which you are employed.

ENROLLMENT PERIOD..... means the period specified in the Benefit Program Application during which you may apply for coverage if you did not apply prior to your Eligibility Date or if you did not apply for Family Coverage when eligible to do so.

FAMILY COVERAGE..... means coverage for you and your eligible dependents under the Health Care Plan.

INDIVIDUAL COVERAGE..... means coverage under the Dental Health Care Plan for you but not your spouse and/or dependents.

INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES ..... means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Federal Drug Administration at the time used or administered to you.

MEDICALLY NECESSARY..... SEE EXCLUSIONS SECTION OF THIS BENEFIT BOOKLET.

OUTPATIENT..... means that you are receiving treatment while not an Inpatient.

PHYSICIAN..... means a physician duly licensed to practice medicine in all of its branches.

PROVIDER..... means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you.

SURGERY..... means the performance of any medically recognized, non-Investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claim Administrator.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS..... means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

USUAL AND CUSTOMARY FEE..... means the fee as reasonably determined by the Claim Administrator, which is based on the fee which the Physician, Dentist, Podiatrist, Psychologist, Chiropractor or Optometrist who renders the particular service usually charges his patients for the same service and the fee which is within the range of usual fees other Physicians, Dentists, Podiatrists, Psychologists, Chiropractors or Optometrists of similar training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances. However, if the Claim Administrator reasonably determines that the Usual and Customary Fee for a particular service is unreasonable because of extenuating or unusual circumstances, the Usual and Customary Fee for such service shall mean the reasonable fee as reasonably determined by the Claim Administrator.

ELIGIBILITY SECTION

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your dental care expenses are covered, not the dental care expenses of other members of your family.

FAMILY COVERAGE

If you have Family Coverage, your dental care expenses and those of your enrolled spouse and your (or your spouse's) enrolled unmarried children who are under age 19 will be covered. Enrolled unmarried children who are full-time students will be covered up to age 25. Coverage ends on the last day of the month.

Any children who are dependent upon you for support and maintenance because of mental retardation or physical handicap will be covered regardless of age if they were covered prior to reaching the limiting age stated above.

Any children who are in your custody under an interim court order prior to finalization of adoption will be covered. This coverage includes benefits for foster children.

This coverage does not include benefits for grandchildren or step-children who do not reside in your home.

CHANGING COVERAGE STATUS

You can change your Coverage Status, or you can add additional dependents to your Family Coverage either because of:

- marriage
- divorce
- legal separation
- a previously ineligible dependent becomes eligible
- the birth or adoption of a child

If you make application for this change within 31 days of the marriage, divorce, legal separation, date previously ineligible dependent become eligible, birth, adoption, or court order. Coverage always starts on the first of the next month. Your Group Administrator will provide you with the application.

In addition, your coverage status can be changed when your spouse's coverage terminates because of layoff or termination of employment. In such case, documentation must be submitted to the Claim Administrator within 31 days of the date on which your spouse's coverage terminates because of such layoff or termination. Such changes would then be effective on such date of termination.

If you do not make application to add dependents to your coverage within those 31 days, you can make application for coverage during the Enrollment Period according to the terms outlined in the Employer's Policy Statement. Such changes would then be effective on a date determined by your Employer. Please contact your Employee Benefits Department for more information.

TERMINATION OF COVERAGE

You will no longer be entitled to the dental care benefits described in this benefit booklet if either of the events stated below should occur.

1. If you no longer meet the previously stated description of an Eligible Person.
2. If the Dental Care Plan of your Employer terminates.

Further, termination of the agreement between the Claim Administrator and the Employer automatically terminates your coverage as described in this benefit booklet. It is the responsibility of the Employer to notify you in the event the agreement is terminated with the Claim Administrator. Regardless of whether such notice is provided, your coverage will terminate as of the effective date of termination of the Employer's agreement with the Claim Administrator.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under the Dental Care Plan described in this benefit booklet except as otherwise specifically stated in the "Extension of Benefits in Case of Termination" provisions of this benefit booklet. However, termination of the Employer agreement with the Claim Administrator and/or termination of your coverage under the Dental Care Plan shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

DENTAL BENEFIT SECTION

An important part of proper health care is maintaining good dental health. Your benefit program includes coverage for dental services and this section of your benefit booklet explains what dental services are covered and how much will be paid for them.

The benefits of this section are subject to all of the terms and conditions of this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available, dental services must be Medically Necessary and rendered and billed for by a Dentist or Physician, unless otherwise specified. No payment will be made by the Claim Administrator until after receipt of a Dentist's or Physician's Claim form. In addition, benefits will be provided only if services are rendered on or after your Coverage Date.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Your Dental Benefits include coverage for the following Covered Services as long as these services are rendered to you by a Dentist or a Physician. When the term "Dentist" is used in this Benefit Section, it will mean Dentist or Physician.

Preventive Dental Services

Your Preventive Dental benefits are designed to help you keep dental disease from starting or to detect it in its early stages. Your Preventive Dental Services are as follows:

- Oral Examinations—The initial oral examination and periodic routine oral examinations. However, your benefits are limited to two examinations every benefit period.
- Prophylaxis—The routine scaling and polishing of your teeth. However, your benefits are limited to two cleanings each benefit period.
- Topical Fluoride Application—Benefits for this application are only available to persons under age 18 and are limited to two applications each benefit period.
- Dental X-rays—Benefits for routine X-rays are limited to one full mouth X-ray every thirty-six months and two bitewing X-rays each benefit period.
- Space Maintainers—Benefits for space maintainers are only available to persons under age 16 and not when part of orthodontic treatment.
- Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.
- Sealants–Pit and fissure sealants are only available to persons under age 16.

Primary Dental Services

Your Primary Dental benefits cover a wide range of services that can help you maintain continued good dental health. These services are as follows:

- Fillings
- Extractions, except as specifically excluded under "Special Limitations" of this Benefit Section.
- Oral Surgery, except as specifically excluded under "Special Limitations" of this Benefit Section.
- Endodontics
- Pulp Vitality Tests—Benefits for these tests are limited to once every twelve months.
- Apicoectomies
- Hemisection
- Biopsies of Oral Tissue
- Periodontics/Periodontal Therapy

  Gingivectomy and gingivoplasty; gingival curettage; periodontal scaling and root planing; osseous Surgery; and mucogingival Surgery. Your benefits are limited to one full mouth treatment per benefit period.

  Periodontal examination—Benefits for periodontal examinations are limited to two per benefit period.

  Periodontal maintenance procedures—Benefits for periodontal maintenance procedures are limited to four per benefit period, however, this maximum will be reduced by any routine prophylaxes in the same benefit period. In addition, you must have received periodontal therapy before benefits for these procedures will be provided.
- Stainless Steel Crowns
- General Anesthesia/Intravenous Sedation—If Medically Necessary and administered with a covered dental procedure. Also, the anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation and who is other than the Dentist who performed the dental procedure.
- Home Visits—Visits by a Dentist to your home when medically required to render a covered dental service.

Major Dental Services

Your Major Dental Benefits are designed to help you pay for certain types of more extensive dental services. These services are as follows:

- Repair of Removable Dentures
- Recementing of Crowns, Inlays, Onlays and Bridges
- Inlays, Onlays and Crowns (other than temporary crowns and stainless steel crowns)

- Fixed Bridgework
- Bridge Repairs
- Full and Partial Dentures
- Denture Adjustments, Rebasing and Relining—During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or relined the dentures.

Once you receive benefits for a crown, inlay, onlay, bridge or denture, replacements are not covered until 5 years have elapsed. Also, benefits are not available for the replacement of a bridge or denture which could have been made serviceable.

Orthodontic Dental Services

Your Dental Benefits include coverage for orthodontic appliances and treatments when they are being provided to correct problems of growth and development (which may be the cause of malocclusion, periodontal disease, temporomandibular dysfunction or combinations of these problems). These benefits are subject to the lifetime maximum and limited as follows:

- Diagnostic benefits, including examination, study models, X-rays and all other diagnostic aids, will be provided only once in any 5 year period, beginning with the date of the first visit to the Dentist.
- Benefits will not be provided for the replacement or repair of any appliance used during orthodontic treatment.
- After your orthodontic treatment has been completed, no further orthodontic benefits will be provided until 5 years have elapsed. However, benefits will be available only if you have not reached your lifetime maximum.

BENEFIT PAYMENT FOR DENTAL COVERED SERVICES

Benefit Period

Your Dental benefit period is a period of one year which begins on January 1st of each year. When you first enroll for the coverage described in this benefit booklet, your first benefit period begins on your Coverage Date but ends on the date it would normally end.

Deductible

Each benefit period, you must satisfy a $50 deductible. This deductible applies to Primary Dental Services and Major Dental Services. In other words, after you incur eligible charges of more than $50 of either Primary Dental Services or Major Dental Services in a benefit period, your benefits will begin for those services. When you have Orthodontic Dental Services, you must satisfy a separate $50 deductible per lifetime. Your Preventive Dental Services are not subject to a deductible.

Benefit Payment Level

100% of the Usual and Customary Fee will be paid for the Preventive Dental Services described in this Dental Benefits Section.

80% of the Usual and Customary Fee will be paid for the Primary Dental Services described in this Dental Benefits Section.

50% of the Usual and Customary Fee will be paid for the Major Dental Services described in this Dental Benefits Section.

50% of the Usual and Customary Fee will be paid for the Orthodontic Dental Services described in this Dental Benefits Section.

Benefit Maximum

The maximum amount available for you in dental benefits each benefit period is $1,500. This is an individual maximum. There is no family maximum.

This maximum applies to all of your Dental Covered Services except for Orthodontic Dental Services. Orthodontic Dental Services are subject to a lifetime maximum of $1,000.

Any expenses incurred beyond the benefit maximum are your responsibility.

IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS

Care By More Than One Dentist

If you should change Dentists in the middle of a particular Course of Treatment, benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of benefits.

Alternate Benefit Program

In all cases in which there is more than one Course of Treatment possible, the benefit payment will be based upon the Course of Treatment bearing the lesser cost.

If you and your Dentist or Physician decide on personalized restorations or to employ specialized techniques for dental services rather than standard procedures, the benefits provided will be limited to the benefit for the standard procedures for dental services, as reasonably determined by the Claim Administrator.

Pre-Estimation of Benefits

If your Dentist recommends a Course of Treatment that will cost more than $200, your Dentist should prepare a Claim form describing the planned treatment, copies of necessary X-rays, photographs and models and an estimate of the charges prior to your beginning the Course of Treatment. The Claim Administrator will review the report and materials, taking into consideration alternative adequate Course of Treatment, and will notify you and your Dentist of the estimated benefits which will be provided under this Benefit Section. This is not a guarantee of payment, but an estimate of the benefits available for the proposed services to be rendered.

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This maximum applies to all of your Dental Covered Services except for Orthodontic Dental Services. Orthodontic Dental Services are subject to a lifetime maximum of $1,000.

Any expenses incurred beyond the benefit maximum are your responsibility.

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If you and your Dentist or Physician decide on personalized restorations or to employ specialized techniques for dental services rather than standard procedures, the benefits provided will be limited to the benefit for the standard procedures for dental services, as reasonably determined by the Claim Administrator.

Pre-Estimation of Benefits

If your Dentist recommends a Course of Treatment that will cost more than $200, your Dentist should prepare a Claim form describing the planned treatment, copies of necessary X-rays, photographs and models and an estimate of the charges prior to your beginning the Course of Treatment. The Claim Administrator will review the report and materials, taking into consideration alternative adequate Course of Treatment, and will notify you and your Dentist of the estimated benefits which will be provided under this Benefit Section. This is not a guarantee of payment, but an estimate of the benefits available for the proposed services to be rendered.

Special Limitations

No benefits will be provided under this Benefit Section for:

1. Dental services which are performed for cosmetic purposes.
2. Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders.
3. Oral Surgery for the following procedures:
   - — surgical services related to a congenital malformation;
   - — excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
   - — excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.
4. Dental services which are performed due to an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.
5. Hospital and ancillary charges are not covered.
6. Any services, treatments or supplies included as an eligible benefit under other group hospital, medical and/or surgical coverage.

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

If your coverage under the Dental Care Plan should terminate, benefits will continue for any dental Covered Services, except for periodontal treatment, described in this Benefit Section as long as the Covered Service was begun prior to the date your coverage terminated and is completed within 30 days of your termination date. No benefits will be provided for periodontal treatment after the termination of your coverage under the Dental Care Plan.

EXCLUSIONS—WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— **Dental procedures which are not Medically Necessary.**

PLEASE NOTE THAT IN ORDER TO PROVIDE YOU WITH DENTAL CARE BENEFITS AT A REASONABLE COST, THE DENTAL CARE PLAN PROVIDES BENEFITS ONLY FOR THOSE COVERED SERVICES FOR ELIGIBLE DENTAL TREATMENT THAT ARE MEDICALLY NECESSARY. IT DOES *NOT* PAY THE COST OF ANY DENTAL CARE PROCEDURES THAT THE CLAIM ADMINISTRATOR DETERMINES WERE NOT MEDICALLY NECESSARY.

No benefits will be provided for procedures which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific procedure provided to you is reasonably required, in the reasonable judgment of the Claim Administrator, for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to you. The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Medically Necessary.

— Services or supplies that are not specifically mentioned in this benefit booklet.

— Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Worker's Compensation Law or other similar laws whether or not you make a Claim for such compensation or receive such benefits.

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except as otherwise provided by law.

— Services or supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

— Services or supplies that do not meet accepted standards of medical and/or dental practice.

— Investigational Services and Supplies and all related services and supplies.

— Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.

— Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.

— Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

— Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

— Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under the Dental Care Plan.

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have dental care coverage through more than one group program. The purpose of COB is to insure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.

2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.

   — However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;

   — When the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

   Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to notify the Claim Administrator, and upon its request, to provide a copy of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claim Administrator has the right in administering these COB provisions to:

— pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.

— recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.

HOW TO FILE A CLAIM

FILING DENTAL CLAIMS

In order to obtain your dental benefits under the Dental Care Plan, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, obtain a Dental Claim Form from your Employee Benefits Department before going to your Dentist. The Dental Claim Form is also used for pre-certification of benefits. It is your responsibility to insure that the necessary Claim information has been provided to the Claim Administrator.

You must complete and sign the Patient Coverage Information Section of the Dental Claim Form. As soon as treatment has ended, ask your Dentist to complete and sign the Billing Dentist Section of the Dental Claim Form, and file it with:

CompDent
200 W. Jackson Blvd.
9th Floor
Chicago, IL 60606

Claims must be filed with the Claim Administrator on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished in the succeeding calendar year.) Claims not filed within the required time period will not be eligible for payment.

CLAIM REVIEW PROCEDURES

The Claim Administrator will process your Claims no later than 90 days after receiving them. In some cases, an additional 90 days may be needed and you will be notified of this during the first 90 day period.

If your Claim is denied (in whole or in part), you will receive a written explanation of the denial. Should your Claim be denied (or if 180 days have elapsed since it was filed and you have not received a written decision), you may have your Claim reviewed. To do so, you must request a review no later than 60 days after the denial (or after the end of the 180 day period) by writing to:

CompDent
200 W. Jackson Blvd.
9th Floor
Chicago, IL 60606

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any pertinent documents held by the Claim Administrator, if you make an appointment in writing to do so.

Within 60 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 60 days may be needed for the review and you will be notified of this during the first 60

day period. In any case, by law, no more than 120 days can be taken for a review, even at your request.

You may have someone else represent you in this review procedure as long as you inform the Claim Administrator, in writing, of the name of the person who will represent you.

GENERAL PROVISIONS

(1) PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

(a) Under this Dental Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.

(b) Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.

(c) A Covered Person's claim for benefits under this Dental Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime, before or after Covered Services are rendered to a Covered Person. Coverage under this Dental Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

(2) YOUR PROVIDER RELATIONSHIPS

(a) The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.

(b) The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator.

(c) The use of an adjective such as Participating in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Participating or any similar modifier or the use of a term such as Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

(3) NOTICES

Any information or notice which you furnish to the Claim Administrator under the Dental Care Plan as described in this benefit booklet, must be in writing and sent to the Claim Administrator at its offices at 770 North Halsted Street, Chicago, IL 60622. Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your

address as it appears on the Claim Administrator's records or in care of your Employer.

(4) LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Dental Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements of this benefit booklet. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements of this benefit booklet.

(5) INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under the Dental Benefits Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Claim Administrator may furnish similar information and records (or copies of records) to other Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same.