

PIMA COUNTY DENTAL PLAN



TO: ELIGIBLE EMPLOYEES

It is a pleasure to provide you with this booklet describing your group dental benefits.

Please read this booklet carefully so that you will be aware of the benefits provided by this plan.

It is our sincere hope that each of you and your dependents enjoy good dental health, but the fact cannot be overlooked that dental care can be expensive. This benefit program has been designed to substantially offset these expenses.

Sincerely,

PIMA COUNTY
BOARD OF SUPERVISORS

PIMA COUNTY DENTAL PLAN

TABLE OF CONTENTS

ARTICLE I: SCHEDULE OF BENEFITS 3

ARTICLE II: ELIGIBILITY..... 3

ARTICLE III: TERMINATION 4

ARTICLE IV: CONTINUATION OF COVERAGE..... 5

ARTICLE V: GENERAL PROVISIONS..... 6

ARTICLE VI: GENERAL LIMITATIONS..... 8

ARTICLE VII: DENTAL BENEFITS 10

ARTICLE VIII: DEDUCTIBLE 11

ARTICLE IX: MAXIMUM DENTAL PLAN BENEFIT 11

ARTICLE X: COORDINATION OF BENEFITS 11

ARTICLE XI: HOW DOES THE PROGRAM WORK? 13

ARTICLE XII: DEFINITIONS 13

ARTICLE XIII: CLAIMS APPEAL PROCEDURE..... 16

PROCEDURE FOR FILING A CLAIM 17

NOTE

This Booklet describes the benefits to which covered employees and their eligible dependents are entitled, and the principal provisions affecting them. It does not constitute the Plan Document or applicable Policies of Insurance, which govern the determination of payable covered benefits. These may be examined at any reasonable time in the Human Resources Department.

ARTICLE I: SCHEDULE OF BENEFITS

Amended/Effective 7/1/13 *

The Calendar Year Deductible is **WAIVED** for diagnostic and preventive services

SECTION 1.01: DENTAL BENEFITS

Deductible: \$50 for one (1) Covered Person, not to exceed \$150 for all Covered Persons per family per Calendar Year.

Maximum Plan Benefit per person: \$ 2,000 per Calendar Year * (*Annual limit is increasing from \$1,000*)

The Usual, Customary, and Reasonable eligible charge for the following services:

- | | |
|-----------------------|--|
| 1. Diagnostic | 80% |
| 2. Preventative | 80% |
| 3. Restorative | 80% |
| 4. Endodontic | 80% |
| 5. Periodontics | 80% * (<i>Lifetime limit has been removed</i>) |
| 6. Prosthetics | 50% |
| 7. Oral Surgery | 80% |
| 8. Orthodontics | 50% * (<i>Lifetime limit has been removed</i>) |
| 9. Prescription Drugs | 80% |

ARTICLE II: ELIGIBILITY

All persons may become covered as Covered Employees or Covered Dependents, as they become eligible subject to the following:

SECTION 2.01: All employees are eligible if they normally work at least twenty (20) hours per week at their customary place of employment, and perform all of the duties of their employment.

SECTION 2.02: Upon initiation of this Plan, all employees currently participating in the Pima County Group Dental Insurance Plan will be covered immediately. All eligible employees thereafter will be covered on the first day of the month immediately following, the completion of one (1) month of regular employment, provided:

- (a) He/she completes an on-line enrollment for the coverage provided herein; and
- (b) He/she agrees to pay any required contributions toward the cost of the coverage; and
- (c) He/she is actively at work on that date or available for work if it is not a scheduled work-day. Otherwise, he/she will be covered on the first day they are actively at work thereafter.

SECTION 2.03: If an employee does not enroll for Dental benefits within one (1) month after the date he/she becomes eligible, or enrolls during the Open Enrollment period, such benefits will not be effective until the next Plan year provided:

- (a) He/she completes the on-line enrollment process enrolling for the coverage provided herein; and
- (b) He/she agrees to pay any required contributions toward the cost of the coverage; and
- (c) He/she is actively at work on that date or available for work if it is not a scheduled work day. Otherwise he/she will be covered on the first day actively at work thereafter.

SECTION 2.04: If application for coverage or for reinstatement is made by an employee who is in an eligible status, but whose coverage had never become effective or had terminated because of failure to make the required contributions for employee's coverage, the coverage for such person shall take effect only in accordance with the conditions set forth in Section 2.03 preceding.

SECTION 2.05: Dependents may be covered simultaneously with employees, if so elected by the Covered Employee covering them as dependents. Newborn children must be enrolled within I month of birth, or during any subsequent open enrollment period, in order to be covered.

SECTION 2.06: If a Covered Employee enrolls for dependent Dental benefits later than one (1) month after becoming eligible for such coverage, or if he/she applies for reinstatement of dependent Dental benefits which had terminated while he/she remained in an eligible status under the Plan, such coverage shall become effective in accordance with Section 2.03.

SECTION 2.07: If additional dependents, other than Newborn children, are acquired by a Covered Employee who has dependent Dental benefits, or if the Covered Employee enrolls for dependent Dental benefits later than one (1) month after becoming eligible for such coverage, the Dental benefits for each such dependent shall become effective on the date the dependent qualifies for such coverage in accordance with Section 2.03 and the definition of Covered Dependents.

SECTION 2.08: If no contributions are required from the individual for Dependent Coverage, he/she will be deemed to have enrolled his/her dependents on the date he/she becomes eligible for such coverage.

SECTION 2.09: Any person enrolled in a Prepaid Dental plan is not eligible to enroll in the Pima County Dental Plan.

ARTICLE III: TERMINATION

Covered Employees and their Covered Dependents who have been eligible for the benefits of this Plan, shall cease to be eligible for the benefits on the earliest of:

SECTION 3.01: COVERED EMPLOYEE

- (a) At midnight on the last day of the month following the date of termination of his/her

employment; or

- (b) At midnight on the last day of the pay period following the date the employee ceases to be in a class of employees eligible for the coverage; or
- (c) At midnight on the last day of the pay period following the due date the employee fails to make any required contribution for the coverage; or
- (d) At midnight on the last day of the pay period following the date this Plan is discontinued, with respect to the Employer; or
- (e) At midnight on the last day of the pay period following the date this Plan is discontinued, with respect to the class of employees to which such employee belongs; or
- (f) At midnight on the last day of the pay period following the date the Plan terminates; or
- (g) At midnight on the date the employee becomes an active member of the Armed Forces of any country; or
- (h) At midnight on the date the employee voluntarily elects to be terminated from the Plan.

SECTION 3.02: COVERED DEPENDENT

- (a) At midnight on the date the employee's coverage terminates in accordance with the "**TERMINATION**" Provision; or
- (b) At midnight on the date ending the period for which the last contribution is made for the employee's dependent coverage; or
- (c) At midnight on the date of termination of all or any dependent coverage under the Plan; or
- (d) At midnight on the date on which he/she ceases to be an eligible dependent under this Plan; or
- (e) At midnight on the date the Covered Dependent becomes an active member of the Armed Forces of any country; or
- (f) At midnight on the date the Covered Dependent becomes eligible for coverage as an employee.

SECTION 3.03: TERMINATION OF THE PLAN

The termination of the Plan shall automatically occur upon the first day following thirty (30) days written notice of termination of the Plan.

ARTICLE IV: CONTINUATION OF COVERAGE

SECTION 4.01: Employee and Dependent coverage may continue if the required contributions are paid by the Covered Employee (subject to the rules precluding individual selection) for any Covered Employee granted leave of absence. Such coverage may continue to the end of twelve (12) months following the pay period in which the leave of absence is approved.

SECTION 4.02: Should coverage terminate while the employee is granted leave of absence, coverage will be reinstated on the first day of the month following the employee's return to active service in an eligible status, provided that:

- (a) The employee returns within twelve (12) months after the termination of coverage and immediately after cessation of either of the above events; and
- (b) Contributions for his/her coverage are resumed.

SECTION 4.03: If a Covered Person is totally disabled on the date his/her coverage terminates, the Dental Expense Benefit will be extended during the continuance of the disability, with respect to the Dental Injury or Dental Condition causing the disability, if such person is not or does not become covered under any other plan which entitles such person to any benefits for the Dental Injury or Dental Condition.

Provided, however, the benefits will be extended only to the end of the Calendar Year following the Calendar Year in which such event occurs and eligibility was established.

SECTION 4.04: There is no Extension of Coverage if this Plan is terminated.

SECTION 4.05: Under provisions of the 1986 and 1989 Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), you and your dependent (s) may continue coverage in the Pima County Dental Plan following certain "Qualifying Events."

A member may choose to continue coverage for himself/herself and his/her dependents until the last day of the month following 18 months after these "Qualifying Events."

- a) Loss of employment (other than gross misconduct).
- b) Your work hours each week are less than the minimum required to be eligible for the dental program.
- c) Retirement
- d) Approval of Long Term Disability

Dependents may choose to continue coverage until the last day of the month following 36 months after these "Qualifying Events":

- a) An enrolled member's death
- b) Divorce or legal separation from an enrolled member.
- c) A child ceases to be an eligible dependent under the dental plan.
- d) Medicare eligibility by an enrolled member.

You or your dependents must notify the Pima County Human Resources Department within 30 days after one of the "Qualifying Events" occurs. Your option to continue coverage will be lost if you fail to notify the Human Resources Department of the "Qualifying Event." The Human Resources Department will advise you of your rights to continue coverage when they become aware of a "Qualifying Event." You will be told how much you will be charged to continue coverage as permitted by federal law, which may not exceed 102% of the premium for an active member. You must tell your employer within 60 days after the "Qualifying Event", whichever is later, if you want to continue coverage. You must pay premiums due within 45 days from the date you elected to continue coverage.

If you were disabled (as defined by the Social Security Administration) at the termination of employment or when hours were reduced, you are entitled to an additional 11 months of coverage. Coverage will end on the last day of the month after:

- a.) The number of months permitted for continued coverage expires; or
- b.) The premiums are not paid; or
- c.) The Pima County Dental Plan is discontinued; or
- d.) The individual becomes covered under any other group dental plan (as a member or otherwise) which does not contain any pre-existing condition exclusions or limitations relating to them.

ARTICLE V: GENERAL PROVISIONS

SECTION 5.01: The benefits payable herein shall not be subject in any manner to anticipation, alienation, sale, or transfer.

SECTION 5.02: Benefits shall be paid by the Plan only if notice of claim is made within ninety (90)

days from the date on which covered charges were incurred. The claimant must submit properly completed claim forms and itemized statements as authorized by the Insurance Review Committee. Any exceptions to the submission of the claims later than ninety (90) days are subject to their approval, but in no event may claims be considered for payment later than fifteen (15) months from the date on which covered charges were incurred.

SECTION 5.03: In the event the County determines that the Covered Person is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Covered Person has not provided the County with an address at which he/she can be located for payment, the County may, during the lifetime of the Covered Person, pay any amount otherwise payable to the Covered Person, to the spouse, or relative by blood of the Covered Person, or to any other person or institution determined by the County to be equitably entitled thereto; or, in the case of the death of the Covered Person before all amounts payable have been paid, the County may pay any such amount to one or more of the following surviving relatives of the Covered Person: Lawful spouse, child or children, mother, father, brothers or sisters, or to the Covered Person's estate, as the County in its sole discretion may designate. Any payment in accordance with the Provision shall discourage the obligation of the County hereunder to the extent of such payment.

SECTION 5.04: No employee, dependent, or other beneficiary shall have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to eligibility, type, amount, or duration of benefits under this Plan, or any amendment or modification thereof, shall be resolved by the County under and pursuant to this Plan, and its decision of the dispute shall be final and binding upon all parties to the dispute. No action may be brought for benefits provided by this Plan or any amendment or modification thereof, or to enforce any right hereunder until the claim has been submitted to and determined by the County, and thereafter the only action which may be brought is one to enforce the decision of the Board. No such action may be brought, unless brought within one year after the date of such decision.

SECTION 5.05: The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Worker's Compensation Insurance laws or similar legislation.

SECTION 5.06: The County, at its own expense, shall have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require, during the pendency of any claim. Proof of Claim forms, as well as other forms and methods of administration and procedure, will be solely determined by the County.

SECTION 5.07: To carry out its obligation, to maintain, within the limits of the funds available to it, a sound economic program dedicated to providing the maximum possible benefits for Covered Employees and Covered Dependents, the County expressly reserves the right, in its sole discretion and without notice to eligible individuals, but on a nondiscriminatory basis:

- (a) To amend either the amount or conditions with respect to any benefits or Provisions of the Plan; and
- (b) To alter or postpone the method of payment of any benefit; and
- (c) To amend any Provisions of these Rules and Regulations.

SECTION 5.08: If payments in excess of the correct amount due are made in error, the County may recover all excess amounts paid. Recovery will be made by reducing or suspending future plan payments, or by requiring the Covered Person to pay back the overpayment in full, or installments, until the overpayment is recovered.

ARTICLE VI: GENERAL LIMITATIONS

The benefits described herein do not cover:

SECTION 6.01: Dental Injury or Dental Condition resulting from war or any act of war, whether war is declared or undeclared;

SECTION 6.02: Dental Injury or Dental Condition resulting from any attempt at suicide or from an intentionally self-inflicted Injury, whether the Covered Person is sane or insane;

SECTION 6.03: Dental care or treatment, services, or supplies in a hospital owned or operated by the United States Government, any agency thereof, or a State or political subdivision, or paid for by the United States Government, or any agency thereof, or by any State, unless the Covered Person is legally required to pay the expenses thereof;

SECTION 6.04: Examination or visits not incidental to or necessary to diagnose a Dental Injury or Dental Condition;

SECTION 6.05: Dental Injury or Dental Condition for which the person on whose behalf claim is presented is not under the regular care of a Physician.

SECTION 6.06: Dental Injury or Dental Condition resulting from or sustained as a result of being engaged in an illegal occupation, commission of, or attempted ' commission of, an assault or felonious act;

SECTION 6.07: Dental Injury or Dental Condition which is sustained while the person is not covered hereunder;

SECTION 6.08: Dental Injury caused by participating in civil insurrection or a riot;

SECTION 6.09: Charges for any condition or disability which would entitle the Covered Person to any benefit under a Worker's Compensation Act or similar legislation, or which is due to Dental Injury or Dental Condition arising out of or in the course of any occupation or employment for wage or profit.

SECTION 6.10: Professional services performed by a person who ordinarily resides in the Covered Person's household, or who is related to the Covered Person as a spouse, parent, child, brother, or sister, whether such relationship is by blood or exists in law;

SECTION 6.11: Benefits payable on behalf of a Dependent previously covered under this Plan as an Employee during a period of disability which began while the Dependent was covered as an Employee, shall not exceed the benefits that would have been payable during that period of disability had the Dependent remained covered as an Employee;

SECTION 6.12: Charges for services received or supplies purchased outside the United States, Canada, or Mexico, unless the charges are incurred while traveling on business or for pleasure outside the United States, Canada, or Mexico.

SECTION 6.13: Expenses incurred for services, procedures, or supplies which, in the opinion of responsible Dental authorities (such as a Dental association review committee), are considered to be experimental or under investigation;

SECTION 6.14: Expense incurred for more than two oral examinations during any Calendar Year;

SECTION 6.15: Expense incurred for any Dental procedure performed for cosmetic reasons;

SECTION 6.16: Expense incurred for replacement of any existing denture which, in the opinion of the attending physician is, or can be made, satisfactory.

SECTION 6.17: Expense incurred for a temporary full denture;

SECTION 6.18: Expense incurred for replacement of a denture for which benefits were paid under the Plan, if such replacement occurs within five (5) years from the date expense was incurred for the denture; unless:

- (a) Such replacement is made necessary by the initial placement of an opposing full denture or the extractions of natural teeth; or
- (b) The denture is a stayplate or a similar temporary partial denture, and is being replaced by a permanent denture; or
- (c) The denture, while in the oral cavity, has been damaged beyond repair as a result of Injury while Covered.

SECTION 6.19: Expense incurred for:

- (a) tooth implants
- (b) athletic mouth guards
- (c) oral hygiene
- (d) dietary or plaque programs
- (e) other educational programs
- (f) duplicate prosthetic devices or appliances
- (g) porcelain veneered crowns or pontics placed on or replacing a tooth posterior to the second bicuspid, to the extent the charges exceed the charge that would have been a Covered Charge for cast metal crowns or pontics.

SECTION 6.20: Expense incurred for any procedure, which commenced before the date the Covered Person, became covered under the Dental Expense Benefit, or any supplies furnished in connection with such procedure, except that for purposes of this Dental Expense Benefit Limitation, X-rays, and prophylaxis treatment, shall not be deemed to commence a Dental procedure.

SECTION 6.21: Expense incurred for replacement of a lost or stolen appliance.

SECTION 6.22: Orthodontic work, or a program of orthodontic treatment, that commenced prior to eligibility for Orthodontic Benefits under this Plan.

SECTION 6.23: Orthodontic treatment that will occasion major restorative Dental work not ordinarily performed in general dentistry.

SECTION 6.24: Orthodontic treatment for cases in which the desired results are unlikely to be obtained, such as those with severe periodontal problems, poor bone structure, or extremely short roots.

SECTION 6.25: Orthodontic treatment primarily for cosmetic purposes, defined as Class 1 cases.

SECTION 6.26: Orthodontic treatment for patients with severe medical disabilities which may prevent satisfactory orthodontic results.

SECTION 6.27: Orthodontic treatment plans, which in the opinion of the Plan, are unlikely to produce professionally accepted corrections of existing malocclusion.

SECTION 6.28: Surgical or non-Surgical care or treatment of Temporomandibular Joint Dysfunction or Syndrome.

SECTION 6.29: Expenses incurred after termination of coverage under this Plan, except for Orthodontic treatment which was in progress prior to termination, and for which expenses are incurred within three (3) months of such termination.

ARTICLE VII: DENTAL BENEFITS

SECTION 7.01: If, as a result of non-occupational accidental Dental or Dental Condition, a Covered Person shall incur necessary Dental Expenses described in the Article, the Plan will pay the Usual, Reasonable, and Customary eligible charge for specified expenses shown in the "**SCHEDULE OF BENEFITS**" actually incurred during a Calendar Year which exceed the amount of the Deductible, but not to exceed the maximums specified in the "**SCHEDULE OF BENEFITS**".

SECTION 7.02: Dental Expenses are deemed to be incurred on the date on which the service or supply which gives rise to the expense is rendered or obtained.

SECTION 7.03: The term "Covered Dental Expense" means only expense incurred for necessary treatment received by employees or dependents from a dentist which, in the geographical area where treatment is rendered, is the usual and customary procedure for the condition being treated. However, the amount considered as Covered Dental Expense will not exceed the fees and prices regularly and customarily charged for the treatment generally furnished for cases of comparable nature and severity in such geographical area for the following:

- (a) Diagnostic services, including routine oral examinations, including routine oral examinations, including diagnosis, X-rays, and prophylaxis (cleaning, scaling, and polishing), but not including more than two examinations for the same Covered Person in any Calendar Year; sealants for children under the age of 14; extractions; general anesthesia; topical application of fluoride; emergency treatment; oral surgery (including extractions); drugs requiring a prescription by a dentist or physician for dental related services;
- (b) Initial installation of, or addition to, full or partial dentures or fixed bridgework, if such installation or addition is required due to the extraction on or after of the Covered Person's coverage, of one or more natural teeth, injured or diseased, and such denture or bridgework includes the replacement of the extracted tooth, and is completed within twelve months after the date of the extraction (dentures and bridgework will be considered to be initially installed only if the dentures and bridgework do not replace any existing dentures or bridgework);
- (c) Replacement or alteration of full or partial dentures or fixed bridgework, if such change is required due to one of the following events, and if such event occurred on or after the effective date of the Covered Person's coverage, and if the replacement or alteration is completed within twelve (12) months after such event:
 - i. An accidental Injury requiring oral surgery; or
 - ii. Oral surgery treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus, or redundant tissue.
- (d) Replacement of a full denture, if required as a result of structural change within the mouth, and if made more than five (5) years after the installation of the denture, but not a replacement made less than two (2) years after the effective date of the Covered Person's coverage;
- (e) Repair of dentures or bridgework;
- (f) Orthodontic appliances and treatment incurred during a course of orthodontic treatment which begins while the person is covered for Dental Expense benefits.

SECTION 7.04: The Maximum Orthodontic Benefit payable for a Covered Person for any one course of orthodontic treatment (including diagnosis, evaluation, and pre-care), shall be that stated in the "SCHEDULE OF BENEFITS," but the amount of benefits payable for each Covered Person shall in no event exceed the percentage stated in the "SCHEDULE OF BENEFITS."

ARTICLE VIII: DEDUCTIBLE

SECTION 8.01: The Deductible Amount applies during each Calendar Year, and is satisfied when covered Expenses incurred by a Covered Person exceed the Deductible Amount specified in the "SCHEDULE OF BENEFITS". The Deductible Amount is applied in the order of the Plan's receipt of covered expenses.

SECTION 8.02: The Deductible Amount shall apply separately to the Covered Employee, and to each covered Dependent, except that when one covered family member has satisfied the amount for one Covered Person, and the amount for all Covered Persons per family specified in the "SCHEDULE OF BENEFITS" has been satisfied in a Calendar Year, no further Deductible need be satisfied in that Calendar Year.

SECTION 8.03: In order that the Deductible will not be applied late in one Calendar Year, and soon again in the following year, any Covered Expenses incurred during the last three months of a Calendar Year which apply toward each Covered Employee's individual Deductible Amount, and each Covered Dependent's individual Deductible Amount, shall apply in the subsequent Calendar Year, provided the Deductible Amount is satisfied during a period of twelve (12) consecutive months.

SECTION 8.04: Any person covered under this Plan, both as a Covered Employee and as a Covered Dependent during the same Calendar Year, shall have only one Deductible Amount apply to all Covered Expenses incurred by, or on behalf of, such person during the Calendar Year, provided that the coverage on such person was in effect continuously from the date on which the Deductible Amount was satisfied.

ARTICLE IX: MAXIMUM DENTAL PLAN BENEFIT

SECTION 9.01: The Maximum Dental Plan benefit as shown in the "SCHEDULE OF BENEFITS" is the maximum amount of benefits available for any covered Person during each Calendar Year while covered by this Plan, whether or not there has been an interruption in the continuity of his/her coverage.

ARTICLE X: COORDINATION OF BENEFITS

All of the benefits of this Plan are subject to this Provision, and these benefits will be referred to as "Our Plan".

SECTION 10.01: "Plan" means any cash or service benefit plan under which a person is entitled to receive benefits or service for, or by reason of, medical, dental, or vision care, or treatment provided by group plans, insured or noninsured; group, blanket, or franchise insurance coverage; group hospital or medical service plans, and other group prepayment coverage; any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans (including Medicare Parts A and B), and any statute.

SECTION 10.02: The term "Medicare" as used herein means the Medicare Program including Part A and Part B established by Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it is presently constituted or may hereafter be amended. A person shall be considered to be entitled to all of the -coverage provided by Medicare on and after the earliest date he/she would have become so entitled if he/she had promptly submitted all applications and proofs required for such coverage. A person who is entitled to the coverage provided by Medicare will be considered entitled to receive benefits, whether or not application for such coverage or benefits had been made. It shall be deemed that any person eligible for Medicare benefits shall be entitled to Medicare. Covered Employees over age 65 who are in Active Service or totally disabled, and their Covered Dependents over age 65 will have benefits determined **first** under "Our Plan" before the benefits of the Medicare Program, unless otherwise requested in writing.

SECTION 10.03: "Allowable Expense" is any necessary, reasonable, and customary item of expense, a part of which is covered under one of the Plans of the individual for whom claim is made. The reasonable cash value of any benefits provided in the form of services instead of cash will be considered to be both an Allowable Expense, and a benefit paid.

SECTION 10.04: "Claim Determination Period: means one Calendar Year. (Note: This will be the period used in comparing expenses incurred and benefits payable when a person is covered under more than one plan.)

SECTION 10.05: This coordination Provision will be used to determine the benefits of a Covered Employee or Covered Dependent under "Our Plan" when the total benefits payable under "Our Plan" and under all other plans, if there were not coordination Provisions, would exceed the Allowable Expenses incurred by the individual during any Claim Determination period.

SECTION 10.06: When this Provision is applicable to any Claim Determination Period, the benefits that would be payable under "Our Plan" in the absence of this Provision will be reduced so that the total benefits payable for all Allowable Expenses under "Our Plan", and all other plans, will not exceed the total allowable Expense. However, if benefits under "Our Plan" are determined first by the rules which follow, then the benefits under another plan which contain coordination Provisions will not be considered in determining benefits under "Our Plan". Even if claim has not been made, the benefits that would have been payable under another plan will be considered as benefits.

SECTION 10.07: When benefits are provided under "Our Plan" and another plan, which also has a coordination Provision, the person for whom claim is made will have his/her benefits determined as follows:

- (a) Benefits will be determined **first** under the plan where such claimant is covered as an employee before the benefits of a plan covering him/her as a dependent;
- (b) The benefits of a Plan of a parent whose birthday occurs earlier in a calendar year shall cover a dependent child before the benefits of a plan of a parent whose birthday occurs later in a calendar year. The word "birthday" as used in this paragraph refers only to the month and day in a calendar year, not the year in which the person was born.

SECTION 10.08: When benefits are provided under "Our Plan" and another plan which also has a coordination Provision, a dependent child, who has coverage under separate plans as a result of a divorce or separation, will have his/her benefits determined as follows:

- (a) Benefits will be determined first under the plan where the dependent child is covered as a result of a court decree which establishes financial responsibility or health care expenses before the benefits of a plan covering him/her as a dependent of the other natural parent;
- (b) When (a) is not applicable, and the natural parent who has custody of the dependent child has not remarried, benefits will be determined first under the plan

- of the natural parent who has custody of the dependent child before the benefits of a plan of the other natural parent;
- (c) When (a) is not applicable, and the natural parent who has custody of the dependent child has remarried, benefits will be determined **first** under the plan of the natural parent who has custody of the dependent child before the benefits of a plan covering him/her as a dependent of the stepparent, and benefits will be determined **first** under the plan of the stepparent who has custody of the dependent child before the benefits of a plan covering him/her as a dependent of the natural parent without custody;
 - (d) When neither (a), (b), nor (c) is applicable, benefits will be determined under Section 10.07(b).

SECTION 10.09: In applying this coordination Provision, the County, without the consent of any person, may release or obtain necessary information. Any person claiming benefits under "Our Plan" shall furnish to the County such information as may be necessary to implement this Provision. Whenever payments which should have been made under "Our Plan" are made payable to other plans, the County shall have the right to pay to any organization making such other payment, any amount warranted to satisfy the intent of this Provision, and amounts so paid shall be deemed benefits paid under "Our Plan" and, to the extent of such payments, the County shall be **fully** discharged from liability under "Our Plan". The County shall have the right to recover any payments of allowable Expenses in excess of the maximum amount necessary to satisfy the intent of this Provision from any Insurance Companies or any other organization.

ARTICLE XI: HOW DOES THE PROGRAM WORK?

Visit the dentist of your choice. During your first appointment, give the dentist your ID card. The ID card identifies your Group #, your Social Security # and gives the dentist other plan information.

If extensive services are needed, your dentist may complete a claim form to provide a predetermination of benefits and submit the form to:

Ameritas Group
Group Claim Office
P. O. Box 82520
Lincoln, NE 68501-2520
Fax: 402-467-7336
Email: ameritasgroup.com

Ameritas will verify your eligibility and determine the amount of benefit to be paid by the plan. The predetermination letter will be sent to the dentist by Ameritas. The amount of the allowable fee, the amount of benefit to be paid by the Plan and the portion you are required to pay will be shown thereon and should be discussed with the dentist before extensive treatment is begun.

If you assign benefits to the dentist, benefits will be paid directly to the dentist. If you have already paid the dentist and do not assign benefits, reimbursements will be paid directly to you.

ARTICLE XII: DEFINITIONS

ACTIVE SERVICE: An employee will be considered in Active Service with the Employer on a day which is one of the Employer's scheduled work days if he/she is performing in the customary manner the

regular duties of his/her employment with the Employer on a full-time basis on that day, either at one of the Employer's business establishments, or at some location to which the Employer's business requires him/her to travel. An Employee will be considered in Active Service on a day which is not one of the employer's scheduled work days only if he/she was performing in the customary manner of all the regular work duties of his/her employment on the preceding scheduled work day.

CALENDAR YEAR: Means a period of twelve (12) consecutive months beginning with January 1st.

CLAIMS REVIEW: Shall refer to the procedure for handling requests for review of a denial of a claim for benefits involving the Insurance Division, Human Resources Department, and Claim Review Committee.

CLAIMS REVIEW COMMITTEE: Shall mean two or more persons employed by the Contract Administrator responsible for the determination of all requests for review of a denial of a claim for benefits.

CO-LIABILITY: Shall mean the percentage payable by the Plan for covered expenses as shown in the "SCHEDULE OF BENEFITS".

CONTRACT ADMINISTRATOR: Shall mean the person or firm employed by the County who is responsible for the processing of claims and payment of benefits, administration, accounting, reporting, and other services contracted for by the County.

CONTRIBUTIONS: Shall mean the amount payable by the Employer or the amount payable by the Employer/Employee jointly for participation.

COVERED DEPENDENTS: Shall be those who are eligible as defined in Pima County Personnel Policy 8.122.

COVERED EMPLOYEE: Shall refer to an employee of an Employer (as defined in the Plan or Trust) who is eligible hereunder and who has been enrolled in the Plan. To be considered as a Covered Employee, the employee must satisfy the requirements as stipulated in the "ELIGIBILITY PROVISION".

COVERED PERSON: Shall refer to a Covered Employee or a Covered Dependent.

DEDUCTIBLE AMOUNT: The Deductible Amount for each Covered Person during each Calendar Year shall be the amount shown in the "SCHEDULE OF BENEFITS" and described in the "DEDUCTIBLE" provision.

DENTAL CONDITION: Shall mean dental disease, and treatment must be rendered by a physician.

DENTAL - COURSE OF TREATMENT: Means all treatment performed in the oral cavity during one or more sessions as a result of the same diagnosis, including examinations, x-rays, prophylaxis, and any complications arising during such treatment.

DENTAL – DIAGNOSIS: Shall mean the necessary procedures to assist the dentist in evaluating the conditions existing, and the dental care required.

DENTAL – ENDODONTICS: Shall mean the necessary procedures for pulpal and root canal therapy.

DENTAL INJURY: Shall mean a condition which results independently of all other causes, and is a result of an externally violent force, and treatment is rendered by a physician.

DENTAL - ORAL SURGERY: Shall mean the necessary procedures for extractions and other oral surgery, including pre- and post-operative care.

DENTAL - ORTHODONTIA: Shall mean the prevention and correction of irregularities of the teeth and malocclusion.

DENTAL – PERIODONTICS: Shall mean the necessary procedures for treatment of the tissues supporting the teeth.

DENTAL – PREVENTATIVE: Shall mean the necessary procedures or techniques to prevent the occurrence of dental abnormalities or disease.

DENTAL – PROSTHODONTICS: Shall mean the necessary procedures associated with the construction, placement, or repair of fixed bridges, partial and complete dentures, crowns, inlays, onlays, and gold restorations.

DENTAL – RESTORATIVE: Shall mean the necessary procedures to restore the teeth.

DENTAL - TREATMENT PLAN: Means the written report made by the dentist or physician describing the findings of his/her examination of a Covered Person while such person is covered, and recommended treatment for the person's dental disease or defect or accident causing injury to teeth.

EMPLOYER: As used herein shall mean Pima County.

ENROLL: To make on-line application for coverage on the ADP/HR Benefits Solutions (Employease) web site. The link is available on the Pima County Benefits web site at <http://www.pima.gov/hr/EmployeeBenefits/index.htm>. Enrollment is not completed until such requests are received by the Contract Administrator.

EXPENSE INCURRED: Shall mean only the fees and prices regularly and customarily charged for the medical services and supplies generally furnished for cases of comparable nature and severity in the particular geographical area concerned. Any agreement as to fees or charges made between the individual and the doctor shall not bind the County in determining its liability with respect to expense incurred. Expense incurred is deemed to be incurred on the date on which the service or supply which gives rise to the expense or charge is rendered or obtained.

MEDICARE: Shall mean Title XVIII (health insurance for the aged) of the United States Social Security Act as amended by Social Security Amendment of 1965, or as later amended.

OPEN ENROLLMENT: Shall mean a period of time during which eligible employees and their eligible dependents are allowed to select between Dental benefits under this Plan, or benefits provided by a Prepaid Dental Plan.

PHYSICIAN: Shall mean only a person acting within the scope of his/her license, and holding the degree of:

- (a) D.M.D. - Doctor of Medical Dentistry; or
- (b) D.D.S. - Doctor of Dental Surgery. Physician shall not include the Covered Person or his/her Covered Dependents or any person who is the spouse, parent, child, brother, or sister of such Covered Person, or his/her Covered Dependents.

PLAN: Shall refer to the benefits and provisions as described herein.

PRONOUNS: Used in this Plan Document shall apply to both sexes.

TOTAL DISABILITY: Shall mean that the Covered Person, if a Covered Employee, is prevented solely because of a non-occupational Dental Injury or non-occupational Dental Condition from engaging in his/her regular or customary occupation, and is performing no work of any kind for compensation or profit, or if a Covered Dependent is prevented solely because of a non-occupational Dental Injury or non-occupational Dental Condition from engaging in all of the normal activities of a person of like age and sex in good health, and is under the regular care and attendance of a physician who certifies as to the Covered Person's disabilities.

USUAL, CUSTOMARY, AND REASONABLE CHARGES: Are charges that may be defined as follows:

USUAL: A "usual" fee is that fee usually charged for a given service by an individual dentist to all his private patients, i.e., his own usual fee.

CUSTOMARY: A fee is "customary" when it is within the range of usual fees charged by dentists of similar training and experience for the same service within that same specific and limited geographic area, as determined by HIIA, MDR, or similar provider of UCR schedules.

REASONABLE: A fee is "reasonable" when it meets the above two criteria and when it is justifiable considering the special circumstances of the particular case involved.

VISIT: Shall mean a personal interview between the physician and Covered Person.

WAITING PERIOD: Employees are eligible for benefits on the date the employee satisfied the time period stipulated in the **ARTICLE II - ELIGIBILITY**.

ARTICLE XIII: CLAIMS APPEAL PROCEDURE

Remedies available for the redress of claims which are denied in whole or in part:

1. If the claim is received by the Claims office, reviewed, and determined to be ineligible under the terms of the Plan Document, an initial denial letter will be sent to the Covered Employee advising him/her of the right to a written appeal.
2. The Covered Employee must then make his/her request in writing, within 60 days, for a review of the denial of the claim, based on the Covered Employee providing additional information. The request should include a copy of the initial denial letter, or the name of the Plan, Group Number, and Claim Number, and addressed to:

PIMA COUNTY HUMAN RESOURCES
BENEFITS DIVISION
150 W. CONGRESS, 4TH FLOOR
TUCSON, AZ 85701

3. The Covered Employee will be advised of the decision in writing or by personal interview at the discretion of the Human Resources Department.

Requests for appeal that do not comply with this procedure and time limitations will not be considered, except in cases of extraordinary circumstances.

PROCEDURES FOR FILING A CLAIM

1. Claim forms can be obtained from your Department Benefits Representative, the Human Resources Department, the Pima County web site at: <http://www.pima.gov/hr/EmployeeBenefits/index.htm> or the Ameritas Group website at: www.ameritasgroup.com.

2. Fill out the top portion of the claim, **answering all questions concerning your spouse's employment and other group coverage. Failure to do so will delay processing of your claim.** Be sure to use the employee's social security number on claims filed for dependents.

3. The bottom portion of the claim will be completed by the dentist.

You will be responsible for submitting the claim. Payment for benefits will be sent to you and you will be responsible to the dentist for the full amount of the dental charges.

4. Completed claim forms and any attached information are to be mailed to:

Ameritas Group
P.O. Box 82520
Lincoln, NE 68501-2520

Phone: (800) 487-5553

Fax: (402) 467-7336

E-mail: ameritasgroup.com

CLAIMS NOT SUBMITTED WITHIN 90 DAYS OF DATE OF INCURRENCE ARE SUBJECT TO REVIEW BY THE INSURANCE DIVISION, HUMAN RESOURCES DEPARTMENT.