SUMMARY PLAN DESCRIPTION

County of Hays
PPO Dental Plan

Effective: January 1, 2018

Group Number: 912772

UnitedHealthcare®

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SECTION 1 - WELCOME

Quick Reference Box

- Member services and claim inquiries: Call the number on your ID card.
- Claims submittal address: Dental Claims, P.O. Box 30567, Salt Lake City, UT 84130-0567.
- Online assistance: **www.myuhc.com**.

This Summary Plan Description describes the terms and conditions of Coverage under County of Hays Welfare Benefit Plan ("Plan"). Read this document carefully so that you will have a clear understanding of your Coverage under the Plan. If you have any questions regarding your Coverage or procedures for obtaining Dental Services, you may call the toll-free number shown on your ID card or contact the Plan Administrator. County of Hays is utilizing the services of UnitedHealthcare in the administration of Coverage under the Plan.

Coverage is subject to the terms, conditions, exclusions and limitations of the Plan. As a Summary Plan Description ("SPD"), this document describes the provisions of Coverage under the Plan but does not constitute the entire Plan. You may examine the entire Plan at the office of the Plan Sponsor during regular business hours.

For Dental Services rendered after the effective date of the Plan, this SPD replaces and supersedes any SPD which may have been previously issued to you by the Plan Sponsor. Any subsequent SPDs issued to you by the Plan Sponsor will in turn supersede this SPD.

County of Hays intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice subject to any collective bargaining agreements between the Employer and various unions, if applicable. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

How To Use This SPD

This SPD should be read and re-read in its entirety. Many of the provisions of this SPD are interrelated; therefore, reading just one or two provisions may not give you an accurate understanding of your Coverage.

Your SPD may be modified by the attachment of Amendments. Please read the provision described in these documents to determine the way in which provisions in this SPD may have been changed.

Many words used in this SPD have special meanings. These words will appear capitalized and are defined for you in Section 11, *Glossary*. By reviewing these definitions, you will have a clearer understanding of your SPD.

From time to time, the Plan may be amended. When that happens, a new SPD or Amendment pages for this SPD will be sent to you. Your SPD should be kept in a safe place for your future reference.

Network and Non-Network Benefits

This SPD describes both Network and Non-Network benefit levels available under the Plan.

Network Benefits - These benefits apply when you choose to obtain Dental Services from a Network Dental Provider. Section 3, *How the Plan Works* describes the procedures for obtaining Covered Dental Services as Network Benefits. Unless otherwise noted in Section 4, *Plan Highlights*, Network Benefits generally provide Coverage at a higher level than Non-Network Benefits.

Non-Network Benefits - These benefits apply when you decide to obtain Dental Services from Non-Network Dental Providers. Section 3, *How the Plan Works* describes the procedures for obtaining Coverage of Dental Services as Non-Network Benefits. Unless otherwise noted in Section 4, *Plan Highlights*, Non-Network Benefits are subject to an Annual Deductible and are generally Covered at a lower level than Network Benefits. When you obtain Dental Services from Non-Network Dental Providers, you must file a claim to be reimbursed for Eligible Expenses. For information on the Plan's reimbursement policy guidelines used to determine Eligible Expenses, you should contact UnitedHealthcare at the telephone number on your ID card.

Dental Services Covered Under the Plan

In order for Dental Services to be Covered as Network Benefits, you must obtain all Dental Services directly from or through a Network Dental Provider.

You should always verify the participation status of a Dental Provider prior to seeking services. From time to time, the participation status of a Dental Provider may change. You can verify the participation status by calling UnitedHealthcare. If necessary, UnitedHealthcare can provide assistance in referring you to Network Dental Providers. If you use a Dental Provider that is not a participating Dental Provider, you will be required to pay the amount of the Dental Provider's fee, if any, which is greater than the Eligible Expense.

Only Necessary Dental Services are Covered under the Plan. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease does not mean that the procedure or treatment is Covered under the Plan.

Important Information Regarding Medicare

Coverage under the Plan is not intended to supplement any coverage provided by Medicare, but in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled for Coverage under the Plan. If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare and do not enroll for and maintain coverage under both Medicare Part A and Part B and if the Plan Sponsor is the secondary payer as described in the Section 9, *Coordination of Benefits*, the Plan Sponsor will pay benefits under the Plan as if you were covered under both Medicare Part A and Part B and you will incur a larger out of pocket cost for Dental Services.

If, in addition to being enrolled for Coverage under the Plan, you are enrolled in a Medicare Advantage (Medicare Part C) plan, you must follow all rules of that plan that require you to seek services from that plan's participating Dental Providers. When the Plan Sponsor is the secondary payer, the Plan will pay any benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. If this Plan is the secondary plan and you don't follow the rules of the Medicare Advantage plan, you will incur a larger out of pocket cost for Dental Services.

Identification ("ID") Card

You must show your ID card every time you request Dental Services. If you do not show your card, the Dental Providers have no way of knowing that you are Covered under a Plan issued by the Plan Sponsor.

Contact the Plan Administrator

Whenever you have a question or concern regarding Dental Services or any required procedure, please contact the Plan Administrator or call the telephone number stated on your ID card.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan.
- The factors that impact your cost for coverage.
- Instructions and timeframes for enrolling yourself and your eligible Dependents.
- When coverage begins.
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time employee who is scheduled to work at least 30 hours per week or a person who retires while covered under the Plan.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your Spouse, as defined in Section 11, *Glossary*.
- Your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian.
- An unmarried child age 26 or over who is or becomes disabled and dependent upon you.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under the Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 10, *Other Important Information*.

Cost of Coverage

You and County of Hays share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld — and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Your contributions are subject to review and County of Hays reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Human Resources.

How to Enroll

To enroll, call Human Resources within 31 days of the date you first become eligible for dental Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your dental election. Any changes you make during Open Enrollment will become effective the following January 1.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once Human Resources receives your properly completed enrollment, coverage will begin on the first day of the month following the completion of 55 days of employment. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify Human Resources within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Human Resources within 31 days of the birth, adoption, or placement.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- Your marriage, divorce, legal separation or annulment.
- The birth, legal adoption, placement for adoption or legal guardianship of a child.
- A change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan.
- Loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis.

- Your death or the death of a Dependent.
- Your Dependent child no longer qualifying as an eligible Dependent.
- A change in your or your Spouse's position or work schedule that impacts eligibility for health coverage.
- Contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer).
- You or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent.
- Benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent.
- Termination of your or your Dependent's *Medicaid* or *Children's Health Insurance Program (CHIP)* coverage as a result of loss of eligibility (you must contact Human Resources within 60 days of termination).
- You or your Dependent become eligible for a premium assistance subsidy under *Medicaid* or *CHIP* (you must contact Human Resources within 60 days of the date of determination of subsidy eligibility).
- A strike or lockout involving you or your Spouse.
- A court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact Human Resources within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all dental Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses
- Annual Deductible;
- Annual Maximum Benefit;
- Lifetime Maximum Benefit for Orthodontic Services; and
- Coinsurance.

Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Dentist you prefer each time you need to receive Covered Dental Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Dental Services from Dentists who have contracted to provide those services.

Generally, when you receive Covered Dental Services from a Network Dentist, you pay less than you would if you receive the same care from a non-Network Dentist. Your level of Benefits will be the same if you visit a Network Dentist or non-Network Dentist. Because the total amount of Eligible Expenses may be less when you use a Network Dentist, the portion you pay will be less. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network Dentist.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network Dentist about their billed charges before you receive care. Emergency services received at a non-Network Dentist are covered at the Network level.

Looking for a Network Dentist?
In addition to other helpful information, **www.myuhcdental.com** contains a directory of Network health care professionals and facilities. While Network status may change from time to time, **www.myuhcdental.com** has the most current source of Network information. Use **www.myuhcdental.com** to search for Dentists available under your Plan.

Network Dentists

You may request a directory of Network Dentists free of charge. Keep in mind, a Dentist's Network status may change at any time. To verify a Dentist's current status or request a

Dentist directory, you can call the toll-free number on your ID card or log onto **www.myuhcdental.com**.

Network Dentists are independent practitioners and are not employees of the Plan or the Claims Administrator.

Eligible Expenses

Eligible Expenses are charges for Covered Dental Services that are provided while the Plan is in effect, determined according to the definition in Section 11, *Glossary*. For certain Covered Dental Services, the Plan will not pay these expenses until you have met your Annual Deductible. County of Hays has delegated to UnitedHealthcare Dental the discretion and authority to decide whether a treatment or supply is a Covered Dental Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Don't Forget Your ID Card
Remember to show your ID card every time you receive dental services from a Dentist. If you do not show your ID card, a Dentist has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Dental Services before you are eligible to begin receiving Benefits. There is a combined Annual Deductible for Network and Non-Network Benefits for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Annual Maximum Benefit

The Annual Maximum Benefit is the maximum amount the Plan will pay each calendar year for Covered Dental Services. There is a combined Annual Maximum Benefit for Network Benefits and Non-Network Benefits.

Lifetime Maximum Benefit for Orthodontic Services

The Lifetime Maximum Benefit is the most the Plan will pay for orthodontic services during the entire period you are enrolled in this Plan and any other dental plans offered by County of Hays. There is a combined Network and non-Network Lifetime Maximum Benefit for this Plan.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Dental Services after you meet the Annual Deductible.

SECTION 4 - PLAN HIGHLIGHTS

The table below provides an overview of the Plan's Annual Deductible, Annual Maximum Benefit and Lifetime Maximum Benefits.

Plan Features	Network	Non-Network
Annual Deductible ■ Individual ■ Family	 $50 $150	
Annual Maximum Benefit ■ Individual	 $1,250	
Lifetime Maximum Benefit for Orthodontic Services	$1,250 per Covered Person, per lifetime	

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
DIAGNOSTIC SERVICES		
Bacteriologic Cultures	100%	100%
Viral Cultures	100%	100%
Bite-Wing Radiographs Limited to 1 series of films per 1calendar year Intraoral Bitewing Radiographs	100%	100%
Complete Series or Panorex Radiographs Limited to one time per consecutive 36 months.	100%	100%
Oral/Facial Photographic Images Limited to 1 time per consecutive 36 months.	100%	100%
Diagnostic Casts Limited to one time per 24 months.	100%	100%
Extraoral Radiographs Limited to 2 films per calendar year.	100%	100%
Intraoral - Complete Series (including bitewings) Limited to 1 time per consecutive 36 months. Vertical bitewings cannot be billed in conjunction with a complete series.	100%	100%
Individual Periapical Radiographs Intraoral Periapical Radiographs	100%	100%

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Pulp Vitality Tests Limited to 1 charge per visit, regardless of how many teeth are tested.	100%	100%
Intraoral Occlusal Film	100%	100%
Periodic Oral Evaluation Limited to 2 times per consecutive 12 months.	100%	100%
Comprehensive Oral Evaluation Limited to 2 times per consecutive 12 months. Not Covered if done in conjunction with other exams.	100%	100%
Limited or Detailed Oral Evaluation Limited to 2 times per consecutive 12 months. Only 1 exam is Covered per date of service.	100%	100%
Comprehensive Periodontal Evaluation - new or established patient Limited to 2 times per consecutive 12 months.	100%	100%
Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures Limited to 1 time per consecutive 12 months.	100%	100%

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
PREVENTIVE SERVICES		
Dental Prophylaxis Cleanings Limited to 2 times per consecutive 12 months.	100%	100%
Fluoride Treatments Fluoride Treatments - child Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.	100%	100%
Sealants Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	100%	100%
Space Maintainers Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	100%	100%
Re-Cement Space Maintainers Limited to 1 per consecutive 6 months after initial insertion.	100%	100%
MINOR RESTORATIVE SERVICES		
Amalgam Restorations Fillings Multiple restorations on one surface will be treated as a single filling.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network***
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Composite Resin Restorations Fillings Composite Resin Restorations - Anterior Multiple restorations on one surface will be treated as a single filling.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Gold Foil Restorations Multiple restorations on one surface will be treated as a single filling.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
ENDODONTICS		
Apexification Limited to 1 time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Apicoectomy and Retrograde filling Limited to 1 time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Hemisection Limited to 1 time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Root Canal Therapy Limited to 1 time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Retreatment of Previous Root Canal Therapy Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Root Resection/Amputation Limited to 1 time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Therapeutic Pulpotomy Limited to 1 time per primary or secondary tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Pulpal Therapy (resorbable filling) - Anterior or Posterior, Primary Tooth (excluding final restoration) Limited to 1 time per tooth per lifetime. Covered for anterior or posterior teeth only.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Pulp Caps - Direct/Indirect – excluding final restoration Not covered if utilized solely as a liner or base underneath a restoration.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Pulpal Debridement, Primary and Permanent Teeth Limited to 1 time per tooth per lifetime. This procedure is not to be used when endodontic services are done on same date of service.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
PERIODONTICS		
Crown Lengthening Limited to 1 per quadrant or site per consecutive 36 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Gingivectomy/Gingivoplasty Limited to 1 per quadrant or site per consecutive 36 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Gingival Flap Procedure Limited to 1 per quadrant or site per consecutive 36 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Osseous Graft Limited to 1 per quadrant or site per consecutive 36 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Osseous Surgery Limited to 1 per quadrant or site per consecutive 36 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Guided Tissue Regeneration Limited to 1 per quadrant or site per consecutive 36 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Soft Tissue Surgery Limited to 1 per quadrant or site per consecutive 36 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Periodontal Maintenance Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Full Mouth Debridement Limited to once per consecutive 36 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Provisional Splinting Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network***
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Scaling and Root Planning Limited to 1 time per quadrant per consecutive 24 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report Limited to 3 sites per quadrant, or 12 sites total, for refractory pockets, or in conjunction with scaling or root planing, by report.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
ORAL SURGERY		
Alveoloplasty	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Biopsy Limited to 1 biopsy per site per visit.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Frenectomy/Frenuloplasty	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Incision and Drainage Limited to 1 per site per visit.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Removal of a Benign Cyst/Lesions Limited to 1 per site per visit.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Removal of Torus Limited to 1 per site per visit.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Root Removal Limited to 1 time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Simple Extraction Limited to 1 time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Surgical Extraction of Erupted Teeth or Roots Limited to 1 time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Surgical Extraction of Impacted Teeth Limited to 1 time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Surgical Access, Surgical Exposure, or Immobilization of Unerupted Teeth Limited to 1 time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Primary Closure of a Sinus Perforation Limited to 1 per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Placement of Device to Facilitate Eruption of Impacted Tooth Limited to 1 time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report Limited to 1 time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Vestibuloplasty Limited to 1 time per site per consecutive 60 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Bone Replacement Graft for Ridge Preservation - per site Limited to 1 per site per lifetime Not Covered if done in conjunction with other bone graft replacement procedures.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Excision of Hyperplastic Tissue or Pericoronal Gingiva Limited to 1 per site per consecutive 36 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Appliance Removal (not by dentist who placed appliance) includes removal of arch bar	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Tooth Reimplantation and/or Transplantation Services Limited to 1 per site per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Oroantral Fistula Closure Limited to 1 per site per visit.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
ADJUNCTIVE SERVICES		
Analgesia Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Desensitizing Medicament	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network***
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
General Anesthesia Covered only when clinically Necessary.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Local Anesthesia Not Covered in conjunction with operative or surgical procedure.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Intravenous Sedation and Analgesia Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report Limited to 1 per visit.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Occlusal Adjustment	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Occlusal Guards Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Occlusal Guard Reline and Repair Limited to relining and repair performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network***
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Occlusion Analysis - Mounted Case Limited to 1 time per consecutive 60 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Palliative Treatment Covered as a separate benefit only if no other services, other than exam and radiographs, were done on the same tooth during the visit.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment.) Not Covered if done with exams or professional visit.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
MAJOR RESTORATIVE SERVICES Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Coping Limited to 1 per tooth per consecutive 60 months. Not Covered if done at the same time as a crown on same tooth.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Crowns – Retainers/Abutments Limited to 1 time per tooth per consecutive 60 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Crowns - Restorations Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network*
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Temporary Crowns - Restorations Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Inlays/Onlays – Retainers/Abutments Limited to 1 time per tooth per 60 consecutive months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Inlays/Onlays - Restorations Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Pontics Limited to 1 time per tooth per consecutive 60 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Retainer-Cast Metal for Resin Bonded Fixed Prosthesis Limited to 1 time per tooth per consecutive 60 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Pin Retention Limited to 2 pins per tooth; not covered in addition to cast restoration.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Post and Cores Covered only for teeth that have had root canal therapy.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Re-cement Bridges Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core Limited to those performed more than 12 months after the initial insertion.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network***
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Sedative Filling Covered as a separate benefit only if no other service, other than x-rays and exam, were done on the same tooth during the visit.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Stainless Steel Crowns Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
FIXED PROSTHETICS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Fixed Partial Dentures (Bridges) Limited to 1 time per tooth per consecutive 60 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
REMOVABLE PROSTHETICS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Full Dentures Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network***
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Partial Dentures Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Relining Dentures and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Tissue Conditioning - Maxillary or Mandibular Limited to 1 time per consecutive 12 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Repairs to Full Dentures, Partial Dentures, Bridges Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns. Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
ORTHODONTICS		
Orthodontic Services Services or supplies furnished by a Dentist to a Dependent under age 19 in order to diagnose or correct misalignment of the teeth or the bite. The extended coverage provision does not apply to orthodontic services.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Benefit Description & Limitation	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network***
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
Appliance Therapy, Fixed or Removable Limited to 1 time per consecutive 60 months. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Cephalometric Film Limited to 1 per consecutive 12 months. Can only be billed for orthodontics.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible

SECTION 5 - EXCLUSIONS AND LIMITATIONS: WHAT THE DENTAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Dental Services, except as may be specifically provided for in Section 4, *Plan Highlights*.

Except as may be specifically provided in the Section entitled *Plan Highlights* or through an Amendment to the SPD, the Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

1. Dental Services that are not Necessary.

2. Hospitalization or other facility charges.

3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic Procedures are those procedures that improve physical appearance).

4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.

5. Any Dental Procedure not directly associated with dental disease.

6. Any Dental Procedure not performed in a dental setting.

7. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

8. Placement of dental implants, implant-supported abutments and prostheses.

9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

10. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

13. Replacement of complete dentures, and fixed and removable partial dentures or crowns, if damage or breakage was directly related to Dental error. This type of replacement is the responsibility of the Dental Provider. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.

14. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.

15. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

16. Expenses for dental procedures begun prior to the Covered Person's eligibility with the Plan.

17. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

18. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

19. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

20. Re placement of complete dentures, fixed and removable partial dentures, or crowns and implants, implant crowns and prosthesis, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.

21. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

23. Services rendered by a Dental Provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.

24. Dental Services otherwise Covered under the Plan, but rendered after the date individual Coverage under the Plan terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Plan terminates, except those conditions Covered under the Extension of Benefits in Section 3.

25. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

26. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

27. Foreign Services are not Covered unless required as an Emergency.

28. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

29. Any Dental Services or Procedures not listed in Section 4, *Plan Highlights*.

SECTION 6 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Dental Services from a Network Dental Provider, the Dental Provider will be paid directly. If a Network Dental Provider bills you for any Covered Health Service other than your Coinsurance, please contact the Dental Provider or call the phone number on your ID card for assistance.

Keep in mind, you are responsible for paying any Coinsurance owed to a Network Dental Provider at the time of service, or when you receive a bill from the Dental Provider.

Non-Network Benefits

If you receive a bill for Covered Dental Services from a non-Network Dental Provider, you (or the Dental Provider if they prefer) must submit the bill for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to the address on the back of your ID card.

If Your Dental Provider Does Not File Your Claim

You can obtain a claim form by visiting **myuhc.com**, calling the toll-free number on your ID card or contacting Human Resources. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Participant.
- The number as shown on your ID card.
- The name, address and tax identification number of the Dental Provider of the service(s).
- A diagnosis from the Dental Provider.
- The date of service.
- An itemized bill from the Dental Provider that includes:
  - The American Dental Association (ADA) codes;
  - A description of, and the charge for, each service;
  - The date the sickness or injury began; and
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For dental claims, the above information should be filed with UnitedHealthcare, at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network Dental Provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non-Network provider is made, County of Hays reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes County of Hays (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to *Refund of Overpayments* in Section 9, *Coordination of Benefits*.

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which

UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Explanation of Benefits (EOB)

You may receive an Explanation of Benefits (EOB) after your claim is processed. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. You can also view and print all of your EOBs online at **myuhc.com**. See Section 11, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- The patient's name and ID number as shown on the ID card.
- The Dental Provider's name.
- The date of Dental Service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30569
Salt Lake City, UT 84130-0569

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent Care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare Dental within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Services or Unproven Services.
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare Dental of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.

- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant dental records.
- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your provider submitted. If there is any information or evidence you or your provider wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a dental condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A final appeal decision, if the determination involves a dental condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received Emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's dental condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination

Post-Service Claims	
Type of Claim or Appeal	**Timing**
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against County of Hays or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against County of Hays or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against County of Hays or the Claims Administrator.

You cannot bring any legal action against County of Hays or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against County of Hays or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against County of Hays or the Claims Administrator.

SECTION 7 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this *Subrogation and Reimbursement* section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a sickness or injury for which any third party is allegedly to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the sickness or injury for which any third party is considered responsible.

Subrogation - Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that sickness or injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement - Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a sickness or injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of sickness or injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Individual, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the sickness or injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the sickness or injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a sickness or injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the subscriber, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 8 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end.
- How to continue coverage after it ends.

County of Hays may, at any time, discontinue this benefit plan and/or all similar benefit plans for the reasons specified in the Plan.

When your coverage ends, County of Hays will still pay claims for Covered Dental Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for Dental Services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your Coverage under the Plan, including Coverage for Dental Services rendered after the date of termination for dental conditions arising prior to the date of termination, will automatically terminate on the earliest of the dates specified below:

- The date in which your employment with the Company ends.
- The date the Plan ends.
- The date you stop making the required contributions.
- The date you are no longer eligible.
- The date UnitedHealthcare receives written notice from County of Hays to end your coverage, or the date requested in the notice, if later.
- The date you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

- The date your coverage ends.
- The date you stop making the required contributions.
- The date UnitedHealthcare receives written notice from County of Hays to end your coverage, or the date requested in the notice, if later.
- The date your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If UnitedHealthcare and County of Hays find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, County of Hays has the right to demand that you pay back all Benefits County of Hays paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Dependent Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- The child is unable to be self-supporting due to a mental or physical handicap or disability.
- The child depends mainly on you for support.
- You provide to County of Hays proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age.
- You provide proof, upon County of Hays's request, that the child continues to meet these conditions.

The proof might include dental examinations at the Plan's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Extended Coverage

A 30 day temporary extension of Coverage, only for the services shown below when given in connection with a Procedure in Progress, will be granted to a Covered Person on the date the person's Coverage is terminated if termination is not voluntary. Benefits will be extended until the earlier of: (a.) the end of the 30 day period; or (b.) the date the Covered Person becomes covered under a succeeding policy or contract providing coverage or services for similar dental procedures.

Benefits will be Covered for: (a.) a Procedure in Progress or Dental Procedure that was recommended in writing and began, in connection with a specific dental disease of a Covered Person while the Plan was in effect, by the attending Dental Provider; (b.) an appliance, or modification to an appliance, for which the impression was taken prior to the termination of Coverage; or (c.) a crown, bridge or gold restoration, for which the tooth was prepared prior to the termination of Coverage.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 11, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if COBRA benefits are available to you.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- A Participant.
- A Participant's enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law.
- A Participant's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
You become entitled to Medicare	N/A	See table below	See table below
County of Hays files for bankruptcy under Title 11, United States Code.[2]	36 months	36 months[3]	36 months[3]

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]This is a qualifying event for any Retired Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3]From the date of the Participant's death if the Participant dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, you Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

*Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a Dental Provider, inform that Dental Provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the dental Plan under COBRA, you have the right to change your coverage election:

- During Open Enrollment.
- Following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- The date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent.
- The date your enrolled Dependent would lose coverage under the Plan.
- The date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide Human Resources with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 12, *Important Administrative Information*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare.
- The date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date).
- The date the entire Plan ends.
- The date coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- The 24 month period beginning on the date of the Participant's absence from work.
- The day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 9 - COORDINATION OF BENEFITS

What this section includes:

- How your Benefits under this Plan coordinate with other plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits Applicability

This coordination of benefits (COB) provision applies when a person has health or dental coverage under more than one Coverage Plan. "Coverage Plan" is defined below.

The order of benefit determination rules below determine which Coverage Plan will pay as the primary Coverage Plan. The primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A secondary Coverage Plan pays after the primary Coverage Plan and may reduce the benefits it pays so that payments from all group Coverage Plans do not exceed 100% of the total allowable expense.

Definitions

For purposes of this Section, Coordination of Benefits, terms are defined as follows:

- A "Coverage Plan" is any of the following that provides benefits or services for dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
  - "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); dental benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
  - "Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-dental components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

  Each contract for coverage under either definition of "Plan" is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.
- The order of benefit determination rules determine whether this Coverage Plan is a "primary Coverage Plan" or "secondary Coverage Plan" when compared to another Coverage Plan covering the person.

  When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When

this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the primary Coverage Plan's benefits.

- "Allowable expense" means a health care service or expense, including deductibles and coinsurance, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services, (for example a dental HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:
  - If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of Usual and Customary fees, any amount in excess of the highest of the Usual and Customary fees for a specific benefit is not an allowable expense.
  - If a person is covered by two or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
  - If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of Usual and Customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the primary Coverage Plan's payment arrangements will be the allowable expense for all Coverage Plans.
- "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.
- "Closed panel Coverage Plan" is a Coverage Plan that provides health or dental benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

- The primary Coverage Plan pays or provides its benefits as if the secondary Coverage Plan or Coverage Plans did not exist.
- A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage will be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major dental coverages that are superimposed over base Coverage

Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.

- A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.
- The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.
  - **Non-Dependent or Dependent**. The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, Subscriber or retiree is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent; and primary to the Coverage Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, Subscriber or retiree is secondary and the other Coverage Plan is primary.
  - **Child Covered Under More Than One Plan**. The order of benefits when a child is covered by more than one Coverage Plan is:
    - The primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:
      - the parents are married;
      - the parents are not separated (whether or not they ever have been married); or
      - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.
    - If the specific terms of a court decree state that one of the parents is responsible for the child's health or dental care expenses or health or dental care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or Coverage Plan years commencing after the Coverage Plan is given notice of the court decree.
    - If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      - the Coverage Plan of the custodial parent;
      - the Coverage Plan of the spouse of the custodial parent;
      - the Coverage Plan of the noncustodial parent; and then
      - the Coverage Plan of the spouse of the noncustodial parent.
  - **Active or inactive employee**. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans

do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule for "Non-Dependent or Dependent"

- **Continuation coverage**. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, Subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.
- **Longer or shorter length of coverage**. The Coverage Plan that covered the person as an employee, member, Subscriber or retiree longer is primary.
- If the preceding rules do not determine the primary Coverage Plan, the allowable expenses will be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

Effect on the Benefits of This Coverage Plan

When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total allowable expenses.

When this Coverage Plan is the secondary carrier, this Coverage Plan will only pay up to the allowable amount but never more than what this Coverage Plan would have paid as primary.

- If a covered person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage Plan, COB will not apply between that Coverage Plan and other closed panel Coverage Plans.
- This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the primary Coverage Plan.

  Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

  - The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
  - The person is enrolled in a Medicare Advantage (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
  - The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
  - The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.

- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Right to Receive and Release Needed Information

Certain facts about health or dental care coverage and services are needed to apply these COB rules and to determine benefits payable under this Coverage Plan and other Coverage Plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming benefits.

The Company does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Coverage Plan must give the Claims Administrator any facts it needs to apply those rules and determine benefit payable. If you do not provide the Claims Administrator the information it needs to apply these rules and determine the benefits payable, your claim for benefits will be denied.

Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, the Claims Administrator (on behalf of the Plan Administrator) may pay that amount to the organization that made the payment. That amount will then be treated as though it was a benefit paid under this Coverage Plan. The Claims Administrator 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.

Right of Recovery

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

SECTION 10 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with the Plan and the Claims Administrator;
- Relationships with Dentists;
- Interpretation of Benefits;
- Information and records;
- Incentives to Dentists and you;
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for dental benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a dental child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare Dental and County of Hays

In order to make choices about your dental coverage and treatment, County of Hays believes that it is important for you to understand how UnitedHealthcare Dental interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare Dental helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare Dental does not provide dental services or make treatment decisions. This means:

- County of Hays and UnitedHealthcare Dental do not decide what care you need or will receive. You and your Dentist make those decisions;
- UnitedHealthcare Dental communicates to you decisions about whether the Plan will cover or pay for the Dental Services that you may receive (the Plan pays for Covered Dental Services, which are more fully described in this SPD); and

- the Plan may not pay for all treatments you or your Dentist may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

County of Hays and UnitedHealthcare Dental may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. County of Hays and UnitedHealthcare Dental will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. County of Hays and UnitedHealthcare Dental will use de-identified data for commercial purposes including research.

Relationship with Dentists

The relationships between County of Hays, UnitedHealthcare Dental and Network Dentists are solely contractual relationships between independent contractors. Network Dentists are not County of Hays's agents or employees, nor are they agents or employees of UnitedHealthcare Dental. County of Hays and any of its employees are not agents or employees of Network Dentists, nor are UnitedHealthcare Dental and any of its employees agents or employees of Network Dentists.

County of Hays and UnitedHealthcare Dental do not provide dental services or supplies, nor do they practice dentistry. Instead, County of Hays and UnitedHealthcare Dental arranges for Dentists to participate in a Network and pay Benefits. Network Dentists are independent practitioners who run their own offices and facilities. UnitedHealthcare Dental's credentialing process confirms public information about the Dentists' licenses and other credentials, but does not assure the quality of the services provided. They are not County of Hays's employees nor are they employees of UnitedHealthcare Dental. County of Hays and UnitedHealthcare Dental do not have any other relationship with Network Dentists such as principal-agent or joint venture. County of Hays and UnitedHealthcare Dental are not liable for any act or omission of any Dentist.

UnitedHealthcare Dental is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

County of Hays and the Plan Administrator are solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

Your Relationship with Dentists

The relationship between you and any Dentist is that of Dentist and patient. Your Dentist is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own Dentist;

- are responsible for paying, directly to your Dentist, any amount identified as a member responsibility, including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your Dentist, the cost of any non-Covered Dental Service;
- must decide if any Dentist treating you is right for you (this includes Network Dentists you choose and Dentists to whom you have been referred); and
- must decide with your Dentist what care you should receive.

Interpretation of Benefits

County of Hays and UnitedHealthcare Dental have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

County of Hays and UnitedHealthcare Dental may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, County of Hays may, in its discretion, offer Benefits for services that would otherwise not be Covered Dental Services. The fact that County of Hays does so in any particular case shall not in any way be deemed to require County of Hays to do so in other similar cases.

Information and Records

County of Hays and UnitedHealthcare Dental may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. County of Hays and UnitedHealthcare Dental may request additional information from you to decide your claim for Benefits. County of Hays and UnitedHealthcare Dental will keep this information confidential. County of Hays and UnitedHealthcare Dental may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish County of Hays and UnitedHealthcare Dental with all information or copies of records relating to the services provided to you. County of Hays and UnitedHealthcare Dental have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Participant's enrollment form. County of Hays and UnitedHealthcare Dental agree that such information and records will be considered confidential.

County of Hays and UnitedHealthcare Dental have the right to release any and all records concerning dental services which are necessary to implement and administer the terms of the

Plan, for appropriate dental review or quality assessment, or as County of Hays is required to do by law or regulation. During and after the term of the Plan, County of Hays and UnitedHealthcare Dental and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your records or billing statements County of Hays recommends that you contact your Dentist. Dentists may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request dental forms or records from UnitedHealthcare Dental, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, County of Hays and UnitedHealthcare Dental will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as does the Plan Administrator.

Incentives to Dentists

Network Dentists may be provided financial incentives by UnitedHealthcare Dental to promote the delivery of dental care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to dental care.

Examples of financial incentives for Network Dentists are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network Dentists receives a monthly payment from UnitedHealthcare Dental for each Covered Person who selects a Network Dentist within the group to perform or coordinate certain dental services. The Network Dentists receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's dental care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network Dentist is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network Dentist.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but County of Hays recommends that you discuss participating in such programs with your Dentist. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

SECTION 11 - GLOSSARY

This Section defines the terms used throughout this SPD and is not intended to describe Covered or uncovered services.

Amendment – any attached description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan except for those which are specifically amended.

Annual Deductible – the amount a Covered Person must pay for Dental Services in a plan year before the Plan will begin paying for Network and Non-Network Benefits in that plan year.

Annual Maximum Benefit – the maximum amount paid for Covered Dental Services during a calendar year for a Covered Person under any Plan offered by County of Hays. The Maximum Benefit is stated in Section 4, *Plan Highlights*.

Claims Administrator – UnitedHealthcare Dental (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Dental Services as described in Section 3, *How the Plan Works*.

Company – County of Hays.

Congenital Anomaly – a physical developmental defect that is present at birth and identified within the first twelve months from birth.

Coverage or **Covered** – the entitlement by a Covered Person to reimbursement for expenses incurred for Dental Services covered under the Plan, subject to the terms, conditions, limitations and exclusions of the Plan. Dental Services must be provided: (1) when the Plan is in effect; and (2) prior to the date that any of the individual termination conditions as stated in the Section entitled Termination of Coverage occur; and (3) only when the recipient is a Covered Person and meets all eligibility requirements specified in the Plan.

Covered Person – either the Participant or an Enrolled Dependent while Coverage of such person under the Plan is in effect. References to "you" and "your" throughout this SPD are references to a Covered Person.

Deductible – see Annual Deductible.

Dental Service or Dental Procedures – dental care or treatment provided by a Dentist to a Covered Person while the Plan is in effect, provided such care or treatment is recognized by the Plan Administrator as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dentist – any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render dental services, perform dental surgery or administer anesthetics for dental surgery.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

Eligible Expenses – Eligible Expenses for Covered Dental Services, incurred while the Plan is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dentists, Eligible Expenses are UnitedHealthcare Dental's contracted fee(s) for the Dental Service with that Dentist.
- For Non-Network Benefits, when Covered Dental Services are received from non-Network Dentist, Eligible Expenses are the Usual and Customary fees as defined below.

Eligible Expenses must not exceed the fees that the Dentist would charge any similarly situated payor for the same services. In the event that a Dentist routinely waives Coinsurance and/or the Annual Deductible for Benefits, Dental Services for which the Coinsurance and/or the Annual Deductible are waived are not considered to be Eligible Expenses.

Emergency – a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Enrolled Dependent – a Dependent who is properly enrolled for Coverage under the Plan.

Experimental, Investigational or Unproven Services – medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time UnitedHealthcare Dental makes a determination regarding coverage in a particular case, are determined to be:

- not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- subject to review and approval by any institutional review board for the proposed use; or
- the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Foreign Services – are defined as services provided outside the U.S. and U.S. territories.

Lifetime Maximum Benefit – the maximum amount paid for Network and Non-Network Benefits for orthodontic services during the entire period of time that the Covered Person is Covered under the Plan or any Plan, offered by County of Hays. The Lifetime Maximum Benefit is stated in Section 4, *Plan Highlights*.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Necessary – Dental Services and supplies which are determined to be appropriate, and

- necessary to meet the basic dental needs of the Covered Person; and
- rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service; and
- consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by UnitedHealthcare Dental; and
- consistent with the diagnosis of the condition; and
- required for reasons other than the convenience of the Covered Person or his or her Dentist; and
- demonstrated through prevailing peer-reviewed dental literature to be either:
  - safe and effective for treating or diagnosing the condition or sickness for which their use is proposed, or,
  - safe with promising efficacy
    - ♦ for treating a life threatening dental disease or condition,
    - ♦ in a clinically controlled research setting; and
    - ♦ using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

    (For the purpose of this definition, the term "life threatening" is used to describe a dental disease, sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dentist has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this SPD. The definition of Necessary used in this SPD relates only to Coverage and differs from the way in which a Dentist engaged in the practice of dentistry may define necessary.

Network – a group of Dentists who are subject to a participation agreement to provide Dental Services to Covered Persons. The participation status of Dentists will change from time to time.

Network Benefits – benefits available for Covered Dental Services when provided by a Dentist who is a Network Dentist.

Non-Network Benefits – coverage available for Dental Services obtained from Non-Network Dentists.

Open Enrollment – the period of time, determined by County of Hays, during which eligible Participants may enroll themselves and their Dependents under the Plan. County of Hays determines the period of time that is the Open Enrollment period.

Participant – an eligible person who is properly enrolled for Coverage under the Plan, as described under *Eligibility* in Section 2, *Introduction*. The Participant is the person (who is not a Dependent) on whose behalf coverage under the Plan is provided.

Plan – County of Hays Dental Plan.

Plan Administrator – County of Hays or its designee.

Plan Sponsor – County of Hays.

Procedure in Progress – all treatment for Covered Services that results from a recommendation and an exam by a Dentist. A treatment procedure will be considered to start on the date it is initiated and will end when the treatment is completed.

Retired Employee – an Employee who retires while covered under the Plan.

Spouse – an individual to whom you are legally married.

Usual and Customary – Usual and Customary fees are calculated based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the Dentist would charge any similarly situated payor for the same services. In the event that a Dentist routinely waives Coinsurance and/or the Annual Deductible for benefits, Dental Services for which the Coinsurance and/or the Annual Deductible are waived are not considered to be Usual and Customary.

Usual and Customary fees are determined solely in accordance with reimbursement policy guidelines. The reimbursement policy guidelines are developed following evaluation and validation of all Dentist billings in accordance with one or more of the following methodologies:

- as indicated in the most recent edition of the Current Dental Terminology (publication of the American Dental Association);
- as reported by generally recognized professionals or publications;
- as utilized for Medicare;
- as determined by dental staff and outside dental consultants; or

- pursuant to other appropriate source or determination.

Waiting Period – period of time for which a Covered Person must wait, after the effective date of Coverage, before dental services listed in the Section titled "Covered Dental Services" will be Covered.

SECTION 12 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

United Healthcare Services, Inc.
Attn: Claims
9900 Bren Road East
Minnetonka, MN 55343

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Dentist; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by UnitedHealthcare Dental. The named fiduciary of Plan is n, the Plan Sponsor.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

ATTACHMENT I – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United Healthcare, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

ATTACHMENT II – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ጥላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY 711)
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর

8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711
9. Cambodian-Mon-Khmer	[illegible] ID [illegible] 0 TTY 711
10. Cherokee	Ꮎ ᎠᏎᏯ ᏰᏢ ᏗᏟᏃᎮᏗ ᏗᏎᏍᏗ ᏂᎪᏍᏔ ᎢᏏ ᏩᏁᏢ ᏈᎧ ᏰᏒ ᏗᎫᎪᏈᏗ ᎠᏟᏍᏈᏗ ᏆᎾᏂᏍᏗᎢ, ᎣᏥᎫᏍᏓᏁ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an

	und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર ફોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono ʻī me ka uku ʻole ʻana. ↵ E kama ʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwụghị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのIDカードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は711です。
28. Karen	[illegible] 0 [illegible] TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافی ئەوەت هەیە کە یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پێناسەی پلانی تەندروستی خۆت و پاشان 0 داگرە. TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນ ຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ, ໃຫ້ໂທຣີຫາຫມາຍເລກໂທລະສັບ ສຳລັບ ສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ, ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दुभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor am maroñ ñan bok jipañ im meļeļe ilo kajin eo am ilo ejjeļok wōņāān. Ñan kajjitōk ñan juon ri-ukok, kūrļok nōmba eo emōj an jeje ilo kaat in ID in karōk in ājmour eo am, jiped 0. TTY 711
35. Micronesian -Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bą́ąh 'ałínígóó bee baa hane'ígíí t'áá ni nizaad bee niká'e'eyeego bee ná'ahoot'i'. 'Ata'halne'í ła yíníkeedgo, ninaaltsoos nit'iz7 'ats'77s bee baa'ahay1 bee n44hozin7g77 bik11' b44sh bee hane'7 t'11 j77k'eh bee hane'7 bik1'7g77 bich'8' hodíilnih dóó 0 bił

	'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin col nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvanian Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست خود تماس حاصل بهداشتی برنامه شناسایی کارت در شده قید رایگان مترجم شفاهی با شماره تلفن نمودهTTY 711 و 0 را فشار دهید.
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ।
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика

	позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan - Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. ↵ TTY 711
50. Sudanic-Fulfulde	Dum hakke maada mballeɗaa kadin keɓaa habaru nder wolde maada naa maa a yoɓii. To a yidi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maada ngol njamu, nyo'u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܐܢܘܫܐ ܕܐܝܬ ܠܗ ܙܟܘܬܐ ܕܢܣܒ ܥܕܪܐ ܘܚܘܒܪܬܐ ܒܠܫܢܗ ܕܠܐ ܡܨܪܝܟ. ܠܡܬܚܢܢܘܬ ܥܠ ܡܬܪܓܡܢܐ، ܩܪܝ ܠܡܢܝܢܐ ܕܛܠܦܘܢ ܕܠܐ ܚܝܒ ܕܟܬܝܒ ܒܟܪܛܝܣ ܕܚܒܪܐ ܕܒܟ ܒ TAM ܕܒܟ ܐܝܟ ܕܐܝܬ ܠܟ ܒ ܡܦܢܓܘ ܕܒܪܝܘܬܐ، ܠܚܘܢ 0. TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంటు మరియు సమాచారం పొందడానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้ โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรสัพท์ถึงหมายเลข โทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรหาหมายเลข 711
56. Tongan -	'Oku ke ma'u 'a e totonu ke ma'u 'a e tokoni mo e 'u fakamatala 'i ho'o lea fakafonua ta'etotongi. Ke kole ha tokotaha fakatonulea, ta ki

Fakatonga	he fika telefoni ta'etotongi ma'ae kau memipa ʻa ee ʻoku lisi ʻI ho'o kaati ID ki ho'o palani ki he mo'uilelei, Lomi'I ʻa e 0. ʻTTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. ¶Ika ka mwochen tungoren aninisin chiakku, koriºewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	اپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. °Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên the ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פאר לאנגען א דאלמעטשער, רופט דעם טאל פריי מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן קארטל, דרוקט ID 0TTY711
63. Yoruba	O ní ẹtọ lati ní iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá òǵbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ ʻ0'. TTY 711