South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan and Trust (MIT)

Enhanced Dental Benefit Summary

(this document is part of the Summary Plan Description for MIT)

Effective January 1, 2026

INTRODUCTION

This Benefit Summary is part of the Summary Plan Description ("SPD") for the South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan and Trust ("MIT").

As used in this Benefit Summary, the *Plan* refers to the enhanced dental plan coverage option offered under MIT. This Benefit Summary is effective as of January 1, 2026.

The purpose of this dental benefit offered by our *Plan* is to provide reimbursement for eligible expenses incurred as a result of *dentally necessary treatment* for *injury* or sickness for the *Adopting Employer's* eligible *employees* and their eligible spouse and dependents.

The *Plan* is not a contract of insurance and the *Participating Employers* do not assume the obligations of an insurer under the *Plan*.

Sun Life Assurance Company of Canada/Sun Life and Health Insurance Company (U.S.) is the Claims Service/Advice Only Administrator for the dental benefits offered by our Plan.

ELIGIBILITY TO OFFER DENTAL COVERAGE

For a Participating Employer to offer dental benefits to its eligible employees and Physicians through MIT, the Participating Employer must maintain 50% participation in dental benefits, based on all of its eligible employees and Physicians (for this purpose, any eligible employee or Physician who provides a valid waiver of coverage is counted as participating).

South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan and Trust (MIT)

Enhanced Dental Benefit

TABLE OF CONTENTS

South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan and Trust (MIT)

Enhanced Dental Benefit

EMPLOYEE AND DEPENDENT DENTAL COVERAGE INFORMATION

(Dependent coverage applies only if elected)

Participant's effective date on file with Plan Administrator

SCHEDULE

Deductible Amount Per Benefit Year

	Network Plan	**Out-of-Network Plan**
Individual Deductible Amount: for Class II and III Dental Services:	$50	$50
Individual Deductible Amount for Class IV Services:	$0	$0
Maximum Family Deductible:	3 persons individually	3 persons individually

The individual deductible does not apply to Class I Network or Out-of-Network Dental Services.

Covered dental expenses incurred toward the deductible amount apply to both the Network and Out-of-Network Plans.

Coinsurance Percentages

	Network Plan	**Out-of-Network Plan**
Class I Preventive Services:	100%	100%
Class II Basic Services:	80%	80%
Class III Major Services:	50%	50%
Class IV Orthodontic Services:	50%	50%

Benefit Maximums	Network Plan	Out-of-Network Plan
Benefit Year Maximum:	$1,000	$1,000
Class IV Orthodontic Services:	$1,000	$1,000

Amounts applied to the benefit maximums will apply to both the Network Plan and Out-of-Network Plan maximums.

Covered dental expenses are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental expenses. However, benefits will be payable based on the most current dental terminology.

ARTICLE ONE

DEFINITIONS

The below terms have the meanings shown here when *italicized*. All other capitalized terms have the meanings set forth in our main SPD.

Active work means the expenditure of time and energy for the *participating employer* or an *associated company* at your usual place of business on a *full-time* basis.

Allowable charge means:

- For a covered dental service rendered by a *network provider*, the *allowable charge* is based on an amount that the *network provider* has agreed to accept.
- For a covered dental service rendered by an *out-of-network provider*, the *allowable charge* is the reasonable charge. The reasonable charge is the charge made by other providers in the area for like *treatment*. A determination by the *Dental Claims Administrator* of what is an *allowable charge* or reasonable charge is final for the purposes of determining benefits payable under the *Plan*.

A determination by the *Dental Claims Administrator* of what is an *allowable charge* is final for the purpose of determining benefits payable under the *Plan*.

Allowable expense means any *dentally necessary*, *usual, and customary charge*, at least a portion of which is covered under 1 or more of the *programs* which cover the person:

- for whom claim is made, and
- on whose account payment is legally required.

When a *program* provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be both an *allowable expense* and a benefit paid.

When benefits are reduced because the person does not comply with the provisions of a *program*, the amount of the reduction will not be considered an *allowable expense*. However, any services rendered by a non-HMO/DMO provider for which the HMO/DMO denies payment will be considered an *allowable expense*.

Benefit year normally means a calendar year beginning on January 1 of any year and ending on December 31 of that year unless a different benefit year has been requested by the Participating Employer and has been approved in writing by MIT.

Claim period means a calendar year or such other annual coverage period as elected by the *Participating Employer* as described in the main SPD. A *claim period* will not start before a person's effective date of participation under this *Plan* nor extend beyond the last day the person is covered under this *Plan*, except where special credits are approved by MIT in special circumstances, such as an acquisition by the *Participating Employer*.

Claimant means an individual who has submitted an application for benefits under the *Plan*.

Contributory means the *Participant* pays part or all of the *Plan* costs and/or benefits through contributions from the *Participant*.

Covered dependent means an *eligible dependent* who is covered under the *Plan*.

Dental Claims Administrator means Sun Life Assurance Company of Canada/Sun Life and Health Insurance Company (U.S.), which has accepted appointment by the *Plan Administrator* to provide certain administrative services with respect to the *Plan*.

Dental coverage means the group dental coverage under the *Plan*.

Dental hygienist means an individual who is licensed to practice dental hygiene and acting under the supervision of a *dentist* within the scope of that license in treating the dental condition.

Dentally necessary and dental necessity mean a *treatment* appropriate for the diagnosis and in accordance with accepted dental standards. The *treatment* must be essential for the care of the teeth and supporting tissues.

Dental treatment plan means the *dentist's* report of recommended *treatment* which contains:

- a list of the charges and dental procedures required for the *dentally necessary* care;

- any supporting pre-operative x-rays; and
- any other appropriate diagnostic materials required.

Dentist means an individual who is licensed to practice dentistry and acting within the scope of that license in treating the dental condition.

Denturist means an individual who is licensed to make dentures and acting within the scope of that license in treating the dental condition.

Eligible class means class of persons eligible to participate under the *Plan*.

Emergency dental care means any *dentally necessary treatment* rendered or received as the direct result of unforeseen events or circumstances which require prompt attention.

Employer means and includes the *Participating Employers*.

Employee means any person employed by an *Employer*. An *Employee* may or may not be a *Participant*.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time, and the regulations and rulings in effect thereunder from time to time.

Family unit means a *Participant* and his *covered dependents*.

Full-Time has the meaning set forth in the main SPD.

Functioning natural tooth means a *natural tooth* which is performing its normal role in the chewing process in the person's upper or lower arch and which is opposed in the person's other arch by another *natural tooth* or prosthetic replacement.

Immediate family member means a person who is related to the *Participant* in one of the following ways: parent, Spouse, child, brother, sister, grandparent, or grandchild.

Medicaid means the Title XIX of the Social Security Act of 1965 as amended.

Natural tooth means any tooth or part of a tooth that is formed by the natural development of the body. Organic portions of the tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp.

Network provider means a *dentist* who is a participant in the *network provider plan*.

Network provider plan means the dental care delivery system in which *network providers* participate and under which we provide certain dental benefits.

Noncontributory means the Trust pays for the entire *Plan* costs and benefits.

Orthodontic treatment means the procedures which provide the corrective movement of teeth through the bone by means of an active appliance to correct a handicapping malocclusion (a malocclusion severely interfering with a person's ability to chew food). Determination of the severity of the malocclusion will be made by the *Dental Claims Administrator*.

Other group dental expense coverage means:
- any other group plan providing benefits for dental expenses; or
- any plan providing dental expense benefits (whether through a dental services organization or other party providing prepaid health or related services) which is arranged through any employer or through direct contact with persons eligible for that plan.

Out-of-network provider means a *dentist* who is not a participant in the *network provider plan* at the time covered dental services are provided.

Out-of-network provider plan means the plan under which we provide certain dental benefits for services received from an *out-of-network provider*.

Participant means an eligible *employee* or Physician who participates in the *Plan*.

Participating Employer has the meaning set forth in the main SPD.

Periodontal maintenance procedures mean recall procedures for patients who have undergone either surgical or non-surgical *treatment* for periodontal disease. The procedures include examination, periodontal evaluation and any further scaling and root planing that is *dentally necessary*.

Plan means the group dental plan established by the *Participating Employer* that describes benefits for *Participants* and their *covered dependents*.

Plan Administrator shall have the same meaning as provided in *ERISA*.

Pre-estimate review means review of a *dentist's* statement, including diagnostic X-rays, describing the planned *treatment,* and expected charges.

Primary program means a *program* whose benefits for health care coverage must be determined without considering the existence of any other *program*. A *program* is *primary* if:

- the *program* has no order of benefit determination rules, or it has rules which differ from *this provision*; or
- under the order of benefit determination rules, this *Plan* determines its benefits first.

Prior plan means the *Employer's* plan of group dental coverage or insurance that was replaced by the *Plan*.

Program means any program which provides benefits or services for medical or dental care or treatment through:

- group, blanket, or franchise insurance coverage;
- group hospital, medical, or dental service prepayment coverage, group or individual practice or other group prepayment coverage, or group-type coverage through Health Maintenance Organizations (HMOs) or Dental Maintenance Organizations (DMOs);
- a labor-management trusteed plan, union welfare plan, employer or employee organization plan or any other arrangement of benefits, not available to the general public, which is based on membership in a group;
- coverage under government programs or coverage required or provided by any statute, except *Medicaid*. Benefits and services provided by Part A and Part B of *Medicare* are included. If the *Participant* or a *covered dependent* are eligible for, but not covered under both Part A and Part B of *Medicare* for any reason, the benefits or services that would have been payable if the *Participant* or the *covered dependent* had been covered, will be included, unless prohibited by federal or state law or regulation; or
- *no-fault motor vehicle coverage* or a Motor Vehicle Financial Responsibility Act, unless prohibited by federal or state law or regulation.

Program does not include any of the following:

- school accident coverage;
- the first $30 per day of benefits under a group or group-type hospital indemnity benefit, written on a non-expense incurred basis;
- Medicaid; and does not include a law or program when, by law, its benefits are in excess of those of any private or other non-governmental plan; or
- no-fault motor vehicle coverage or a Motor Vehicle Financial Responsibility Act, which, according to its rules, determines its benefits after the benefits of this Plan have been determined, or any optional no-fault motor vehicle coverage.

The term *program* will be construed separately for each policy, contract, or other arrangement for benefits or services. It will also be construed separately for:

- that part of any policy, contract, or other arrangement which has the right to consider the benefits or services of other programs in determining its benefits; and
- that part which does not.

School accident coverage means coverage for elementary, high school, or college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from School" basis.

Secondary program is not a *primary program* and may consider the benefits of the *primary program* and the benefits of any other *program* which, under the rules of *this provision*, has its benefits determined before those of that *secondary program*.

Treatment means any dental consultation, service, supply, or procedure that is needed for the care of the teeth and supporting tissues.

Trust means the *Trust* established under the South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan *Trust Agreement*.

ARTICLE TWO
DENTAL PLAN BENEFITS

Benefits Provided
The *Plan* will provide benefits for covered dental expenses identified in this Summary when incurred by the *Participant* or a *covered dependent*, while participating under the *Plan*. The *Plan* will pay at the co-insurance percentage shown in the Schedule after the *Participant* or a *covered dependent* have satisfied any deductible required for the *benefit year*, subject to all the terms and conditions of the *Plan*.

Covered dental expenses will only include *treatment* provided to the *Participant* or a *covered dependent* for which, as outlined in the Covered Dental Expenses section, the date started, and the date completed occur while the person is participating in the *Plan*. No payment will be made for a program of dental *treatment* already in progress on the effective date of a person's participation in the *Plan*, except as stated in the Continuity of Coverage provision, if any. No payment will be made for dental *treatment* completed after the *Participant's* or a *covered dependent's* participation under the *Plan* ends.

Deductible
The deductible is the amount shown in the Schedule and will be applied to each class of dental services as indicated in the Schedule. The deductible is the amount of covered dental expenses that the *Participant* and each *covered dependent* must incur in a *benefit year* before benefits will be paid. When covered dental expenses equal to the deductible amount have been incurred and submitted, the deductible will be satisfied. Benefits will not be paid for covered dental expenses applied to the deductible.

If the deductible amount is increased during a *benefit year*, further covered dental expenses must be incurred after the date of increase to satisfy the additional deductible for that *benefit year*.

The deductible will apply to the *Participant* and each *covered dependent* separately each *benefit year* except as stated in the Maximum Family Deductible section.

Maximum Family Deductible
The family deductible is shown in the Schedule. It indicates the number of persons in the *Participant's family unit* who must each satisfy an individual deductible in order to satisfy the family deductible. Once that number of persons has satisfied a deductible for a *benefit year*, the deductible will be considered satisfied for each person in the *Participant's family unit* for that *benefit year*. Benefits will be paid for covered dental expenses incurred on or after the date the required number of persons has satisfied the deductible amount. Expenses incurred for Class IV: Orthodontic Dental Services will not be applied to the family deductible.

Date Started and Date Completed
If the *Plan* includes any of the following listed services, dental *treatment* is considered to be started as follows:

- for a full or partial denture, on the date the first impression is taken,
- for a fixed bridge, crown, inlay and onlay, on the date the teeth are first prepared,
- for root canal therapy, on the date the pulp chamber is first opened,
- for periodontal surgery, on the date the surgery is performed, and
- for all other *treatment*, on the date *treatment* is rendered;

and dental *treatment* is considered to be completed as follows:

- for a full or partial denture, the date a final completed appliance is first inserted in the mouth,
- for a fixed bridge, crown, inlay and onlay, the date an appliance is cemented in place, and
- for root canal therapy, the date a canal is permanently filled.

See Class IV: Orthodontic Dental Services for start and completion dates for *orthodontic treatment*.

Covered Dental Expenses

Covered dental expenses include only the lesser of the discounted amount agreed upon by the *network provider* under the *network provider plan*, the *dentist's* actual charge, or the *allowable charge* for expenses incurred by the *Participant* or a *covered dependent*. The *treatment* must be:

- performed by or under the direction of a *dentist*, or performed by a *dental hygienist* or *denturist,*
- *dentally necessary,* and
- started and completed while a *covered person* is insured, except as otherwise provided in the Extension of Benefits provisions and Continuity of Coverage, if any.

Expenses submitted must identify the *treatment* performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. The Plan reserves the right to request X-rays, narratives, and other diagnostic information, as seen fit, to determine benefits.

Benefits will only be paid for covered dental expenses incurred for *treatment* which, was determined to have a reasonably favorable prognosis for the patient.

A temporary *treatment* will be considered to be an integral part of the final *treatment*. The sum of the fees for temporary and final *treatment* will be used to determine whether the charges are *usual and customary*.

Covered dental expenses are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental expenses. However, benefits will be payable based on the most current dental terminology.

The following is a complete list of covered dental expenses. Benefits will not be paid for expenses incurred for any service not listed in the *Plan*.

Class I: Preventive Dental Services

- All oral evaluations, limited to 2 times in a calendar year
- Intraoral complete series X-rays, including bitewings and 10 to 14 periapical X-rays, or panoramic film, limited to 1 time in any 36-month period
- Bitewing X-rays (four films), limited to 1 time in any 12-month period
- Dental prophylaxis, limited to 2 times in a calendar year
- Genetic test for susceptibility to oral diseases, limited as follows:
  - Limited to 1 test per lifetime; and
  - Limited to persons over age 18
- Topical fluoride *treatment*, limited to:
  - 1 time in any 6-month period; and
  - Covered dependent children less than age 19;
- Sealants, limited to:
  - 1 time per tooth in any 36-month period;
  - Applications made to the occlusal surface of permanent molar teeth; and
  - Covered dependent children less than age 16.
- Intraoral periapical X-rays
- Intraoral occlusal x-rays, limited to 2 films in any 12-month period
- Extraoral x-rays, limited to 1 film in any 6-month period

Class II: Basic Dental Services

<u>Diagnostic Services</u>

- Accession and examination of tissue

<u>Endodontic Services</u>

- Pulpotomy, limited to covered dependent children less than age 19
- Root canal therapy, including all pre-operative, operative and post-operative X-rays, canal preparation and fitting of preformed dowel or post, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care, limited to 1 time on the same tooth in any 24 month period (including teeth treated prior to the date the coverage takes effect under the *Plan*)
- Apicoectomy/periradicular surgery (anterior, bicuspid, molar, each additional root), including all pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia, and routine follow-up care
- Retrograde filling--per root
- Root amputation--per root

- Hemisection, including any root removal and an allowance for local anesthesia and routine postoperative care, does not include a benefit for root canal therapy

Periodontal Surgical Services

- Periodontal related services as listed below, limited to:
    - 1 time per quadrant of the mouth in any 36-month period with charges combined for each of these services performed in the same quadrant within the same 36-month period
        - Gingivectomy
        - Osseous surgery
- Osseous grafts, limited to *treatment* when periodontal disease is present, excludes grafting after extractions
- Guided tissue regeneration
- Pedicle grafts
- Tissue grafts

Periodontal Non-Surgical Services

- Periodontal scaling and root planing (per quadrant), limited to 1 time per quadrant of the mouth in any 24-month period. Benefits for prophylaxis and scaling and root planing, performed during the same appointment, will be based on the *allowable charge* for a prophylaxis. Benefits for scaling and root planing and *periodontal maintenance procedures*, performed during the same appointment, will be based on the *allowable charge* for *periodontal maintenance procedures*.
- *Periodontal maintenance procedure* (following active *treatment*), limited to 1 dental prophylaxis or 1 *periodontal maintenance procedure* in any 12-month period
- Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth by report, limited to 1 application per tooth in any 12-month period
- Biopsy
- Incision and drainage only if not performed on the same day as an extraction
- General anesthesia and intravenous sedation for the first 30 minutes and one additional 15-minute unit, limited as follows:
    - Considered for payment as a separate benefit only with surgical extractions and when administered in the *dentist's* office or outpatient surgical center in conjunction with oral surgery services which are listed as covered services under the *policy*
    - Benefits for general anesthesia will be based on the benefit allowed for the corresponding intravenous sedation

Other Basic Services

- Palliative (emergency) treatment of dental pain, considered for payment as a separate benefit only if no other *treatment* (except X-rays) is rendered during the visit
- Consultation, including specialist consultations, limited as follows:
    - Considered for payment only if billed by a *dentist* who is not providing operative *treatment*
    - Benefits for restorations on three or more surfaces will be based on the benefit allowed for the corresponding two surface restoration
- Therapeutic drug injections
- Space maintainers, including all adjustments made within 6 months of installation, limited to *covered dependent* children less than age 19 and to one appliance per child.
- Repairs to or recementing of full or partial dentures, bridges, crowns and inlays, limited to repairs or adjustments performed more than 12 months after the initial insertion

Restorative Services (Fillings)

- Amalgam restorations, limited as follows:
    - Multiple restorations on one surface will be considered a single filling
    - Benefits for the replacement of an existing amalgam restoration will only be considered for payment if at least 24 months have passed since the existing amalgam restoration was placed
    - Mesial-lingual, distal-lingual, mesial-facial, and distal-facial restorations will be considered single surface restorations

- Benefits for restorations on three or more surfaces will be based on the benefit allowed for the corresponding two surface restoration

- Composite restorations, limited as follows:
  - Mesial-lingual, distal-lingual, mesial-facial, and distal-facial restorations will be considered single surface restorations
  - Benefits for the replacement of an existing composite restoration will only be considered for payment if at least 24 months have passed since the existing composite restoration was placed
  - Benefits for restorations on three or more surfaces will be based on the benefit allowed for the corresponding two surface restoration

- Pin retention restorations, covered only in conjunction with an amalgam or composite restoration, pins limited to 1 time per tooth.

- Silicate restorations (fillings)

- Repairs to or recementing of full or partial dentures, bridges, crowns and inlays, limited to repairs or adjustments performed more than 12 months after the initial insertion

Class III: Major Dental Services

Oral Surgery Services

- Oral surgery services as listed below, including an allowance for local anesthesia and routine post-operative care
  - Surgical extractions (including extraction of wisdom teeth)
  - Alveoloplasty
  - Vestibuloplasty
  - Removal of lateral exostosis—maxilla or mandible
  - Frenulectomy (frenectomy or frenotomy)
  - Excision of hyperplastic tissue—per arch
  - Orantral fistula closure

  If more than one complex surgical procedure is performed per area of the mouth, only the most inclusive surgical procedure performed will be considered a covered dental expense.

- Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus

- Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Inlay, Onlay, and Crown Restorations

- Inlays and onlays
  - Covered only when there is extensive decay or fracture and the tooth cannot be restored by an amalgam or composite filling,
  - Covered only if more than 10 years have elapsed since last placement, and
  - Limited to persons over age 16.

- Crowns, including porcelain crowns on anterior teeth only (includes an allowance for all temporary restorations and appliances, and 1-year follow-up care)
  - Covered only when there is extensive decay or fracture and the tooth cannot be restored by an amalgam or composite filling,
  - Covered only if more than 10 years have elapsed since last placement, and
  - Limited to persons over age 16.

- Labial veneers (only for anterior teeth)
  - Covered only if more than 10 years have elapsed since last placement, and
  - Limited to persons over age 16.

- Crown build-up, including pins and prefabricated posts

- Post and core, covered only for endodontically treated teeth requiring crowns

Full and Partial Dentures (Removable)

- Full dentures (includes an allowance for all temporary restorations and appliances, and 1-year follow-up care), limited as follows:

  - Limited to 1 time per arch, unless

        - 10 years have elapsed since last replacement, and
        - the denture cannot be made serviceable.
    - The Plan will not pay additional benefits for personalized dentures or overdentures or associated *treatment*

- Partial dentures, including any clasps and rests and teeth (includes an allowance for all temporary restorations and appliances, and 1-year follow-up care), limited as follows:

- Partial dentures, including any clasps and rests and teeth (includes an allowance for all temporary restorations and appliances, and 1-year follow-up care), limited as follows:

    - Limited to 1 partial denture per arch, unless
        - 10 years have elapsed since last replacement, unless there is a *dentally necessary* extraction of an additional *functioning natural tooth,* and
        - the partial denture cannot be made serviceable.
    - There are no benefits for precision or semi-precision attachments

- Each additional clasp and rest

- Denture adjustments, limited to:
    - 1 time in any 12-month period, and
    - Adjustments made more than 12 months after the insertion of the denture.

- Relining or rebasing dentures, limited to:
    - 1 time in any 36-month period, and
    - Relining or rebasing done more than 12 months after the insertion of the denture.

- Tissue conditioning performed more than 12 months after the initial insertion of the denture

Fixed Partial Dentures (Bridges)

- Fixed bridges, limited as follows (includes an allowance for all temporary restorations and appliances, and 1-year follow-up care)

    - Limited to persons over age 16,

    - Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge
        - is more than 10 years old, and
        - cannot be made serviceable.

      unless there is a *dentally necessary* extraction of an additional *functioning natural tooth* and the extracted tooth was not an abutment to an existing bridge

    - A fixed bridge replacing the extracted portion of a hemisected tooth is not covered

Other Major Services

- Stainless steel crowns, limited to:
    - 1 time in any 36-month period,
    - Teeth not restorable by an amalgam or composite filling, and
    - *Covered dependent* children less than age 19.

Class IV: Orthodontic Dental Services

- Diagnostic X-ray, limited to x-rays for orthodontic purposes;
- Diagnostic casts, limited to casts made for orthodontic purposes;
- Surgical exposure of an impacted tooth, limited to services performed for orthodontic purposes;
- Orthodontic appliances for tooth guidance; and
- Fixed or removable appliances to correct harmful habits.

Benefits for *orthodontic treatment* will be provided to *Participants* and their *covered dependents*.

Benefits for *orthodontic treatment* are not payable for expenses incurred for retention of orthodontic relationships. Benefits for *orthodontic treatment* are payable only for active *orthodontic treatment* for the services listed above.

The coinsurance percentage amount shown in the Schedule will be paid after any required deductible for orthodontic services has been satisfied for the *benefit year*. The maximum benefit payable to each *Participant* and *covered dependent*, while covered under the *Plan*, for orthodontic services is shown in the Schedule. The maximum benefit will apply even if Plan coverage ceases and recommences or is otherwise interrupted and regardless of what network provider, claims administrator or insurance company is used by the Plan. Benefits paid for orthodontic services will not be applied to the Benefit Year Maximum shown in the Schedule.

Pre-estimate
If the charge for any *treatment* is expected to exceed $300, a *dental treatment plan* is recommended to be submitted for review before *treatment* begins. An estimate of the benefits payable will be sent to the *Participant* and the *dentist*.

In estimating the amount of benefits payable, the *Plan* will consider whether or not an alternate *treatment* may accomplish a professionally satisfactory result. If the *Participant* or a *covered dependent* and the *dentist* agree to a more expensive *treatment* than that pre-estimated under the *Plan*, the excess amount will not be paid.

The pre-estimate is not an agreement for payment of the dental expenses. The pre-estimate process lets the *Participant* or a *covered dependent* know in advance approximately what portion of the expenses will be considered covered dental expenses under the *Plan*.

Alternate Treatment
If an alternate *treatment* can be performed to correct a dental condition, the maximum covered dental expense consider for payment under the *Plan* will be the most economical *treatment* which will, as determined by the *Dental Claims Administrator*, produce a professionally satisfactory result. The *Plan* will not provide a full payment, a partial payment, or an alternate *treatment* payment for any service that is not a covered dental expense.

Special Limitations

Late Entrant Limitation
If an *employee* applies for *dental coverage* more than 31 days after the *employee* or any eligible dependents first become eligible or after participation in the *Plan* ended because a required contribution was not paid, the *employee* and any eligible dependents are late entrants. The benefits for the first 24 months of coverage for late entrants will be limited as follows:

Time Insured Continuously Under the Policy	Benefits Provided for Only These Services
Less than 6 months	Class I Dental Services
At least 6 months but less than 12 months	Class I & Class II Restorative Services
At least 12 months but less than 24 months	Class I & all Class II Dental Services

The *Plan* will not pay for any *treatment* that is started or completed during the late entrant limitation period.

Missing Teeth Limitation
Benefits will not be paid for replacement of teeth missing on the *Participant's* or a *covered dependent's* effective date of participation under the *Plan* for the purpose of the initial placement of a prosthetic device to replace a missing tooth. However, expenses for the replacement of teeth missing on the effective date of participation will be considered for payment as follows:

- The initial placement of full or partial dentures will be considered a covered dental expense if the placement includes the initial replacement of a functioning natural tooth extracted while the Participant or covered dependent are participating under the Plan.

- The initial placement of a fixed bridge will be considered a covered dental expense if the placement includes the initial replacement of a functioning natural tooth extracted while the Participant or covered dependent are participating under the Plan. However, the following restrictions will apply:

    - The replacement of an extracted tooth will not be considered a covered dental expense if it was an abutment to an existing prosthesis

    - Benefits will only be paid for the replacement of the teeth extracted while the *Participant or covered dependent* are participating under the Plan

    - Benefits will not be paid for the replacement of other teeth which were missing on the *Participant's* or *covered dependent's* effective date of participation under the *Plan*

General Exclusions

Benefits will not be paid for expenses incurred for any of the following:

- *Treatment* or an appliance which
  - Is not included in the list of covered dental expenses
  - Is not *dentally necessary*
  - Is experimental in nature
  - Is temporary in nature
  - Does not have uniform professional endorsement

- *Treatment* related to procedures that are:
  - Part of a service but are not reported as separate services
  - Reported in a *treatment* sequence that is not appropriate
  - Misreported or that represent a procedure other than the one reported

- Appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting

- Any *treatment* or appliance, the sole or primary purpose of which relates to
  - The change or maintenance of vertical dimension
  - The alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery or temporomandibular joint disorder
  - Bite registration
  - Bite analysis
  - Attrition or abrasion

- Replacement of a lost or stolen appliance or prosthesis

- Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions

- Completion of claim forms or missed dental appointments

- Personal supplies or equipment, including but not limited to water piks, toothbrushes, floss holders, or athletic mouthguards, except supplies prescribed and dispensed by a *dentist* related to the bleaching of teeth (subject to the 36-month frequency limitation for the bleaching of teeth)

- Administration of nitrous oxide or any other agent to control anxiety

- *Treatment* for a jaw fracture

- *Treatment* provided by a *dentist*, *dental hygienist*, or *denturist* who is
  - An *immediate family member* or a person who ordinarily resides with a Participant or *covered dependent*
  - An *employee* or Physician employed by or performing services for the *Participating Employer*
  - A *Participating Employer*

- Hospital or facility charges for room, supplies or emergency room expenses or routine chest x-rays and medical exams prior to oral surgery

- *Treatment* provided primarily for cosmetic purposes, except for the bleaching of teeth

- *Treatment* which may not reasonably be expected to successfully correct the person's dental condition for a period of at least 3 years as determined by the *Dental Claims Administrator*

- Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which do not have extensive decay or fracture and can be restored with an amalgam or composite resin filling

- *Treatment* for implants, implant abutments, implant supported prosthetics (crown, fixed partial denture, dentures) or any other

services related to the care and *treatment* of the implant

- *Treatment* for the prevention of bruxism (grinding of teeth)

- *Treatment* performed outside the United States, except for *emergency dental treatment*. The maximum benefit payable to any person during a *benefit year* for covered dental expenses related to *emergency dental treatment* performed outside the United States is $100.

- *Treatment* or appliances which are covered under any workers' compensation law, employer's liability law or similar law. A *Participant* must promptly claim and notify MIT of all such benefits.

- *Treatment* for which a charge would not have been made in the absence of insurance or Plan coverage

- *Treatment* for which a *Participant* or *covered dependent* does not have to pay, except when payment of such benefits is required by law and only to the extent required by law

- Any *treatment* required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joint or its associated structures

Continuity of Coverage
This provision applies only to *Participants* and their *covered dependents* who elect to participate on the effective date of the *Plan*, unless otherwise specified below.

Continuity of Coverage for Participants
The *Plan* will provide continuity of coverage if the *Participant* was covered under the *prior plan* on the day before coverage was replaced by the *Plan*.

If the *Participant*
- is at *active work* on the Effective Date of the *Plan* and
- applies for coverage before or within 31 days of the Effective Date of the *Plan*, the *Participant* will be covered under the *Plan*.

Continuity of Coverage for Eligible Dependents
We will provide continuity of coverage for the *Participant's eligible dependents*, if any, who were covered under the *prior plan* on the day before coverage was replaced by the *Plan,*
- If the dependent is not in a hospital or similar facility on the Effective Date of the *Plan*, and
- the *Participant* applies for dependent coverage before or within 31 days of the Effective Date of the *Plan*.

Prior Extractions
If *treatment* is *dentally necessary* due to an extraction which occurred before the Effective Date of this *Plan* but while the *Participant* or *covered dependent* were covered under the *prior plan* and *treatment* would have been covered under the *Employer's prior plan*, the Coverage for Treatment in Progress provision will be applied as stated below and expenses will be considered as follows:
- the replacement of the extracted tooth must take place within 12 months of extraction; and
- expenses must be covered dental expenses under this *Plan* and the *prior plan*.

Late Entrant Limitations
If the *Participant* or a *covered dependent*:
- was eligible but not covered under the *prior plan* on the day before the *prior plan* was replaced by this *Plan*;
- is eligible to participate on the effective date of this *Plan*; and
- the *Participant* elects participation under this *Plan* before or within 31 days of the Effective Date of this *Plan*,

then the *Participant* and any *covered dependents* will be subject to the Late Entrant Limitation in the Special Limitations section.

Coverage for Treatment in Progress
If the *Participant* or a *covered dependent* was covered under the *prior plan* on the day before the *prior plan* was replaced by this *Plan*, benefits will be paid for any program of dental *treatment* already in progress on the Effective Date of this *Plan* as stated below. However, the expenses must be covered dental expenses under this *Plan* and the *prior plan*.

Extension of Benefits under Prior Plan

This *Plan* will not pay benefits for *treatment* if:

- the *prior plan* has an extension of benefits provision;
- the *treatment* expenses were incurred under the *prior plan*; and
- the *treatment* was completed during the *prior plan's* extension of benefits.

No Extension of Benefits under Prior Plan

This *Plan* will pro-rate benefits according to the percentage of *treatment* performed while insured under the *prior plan* if:

- the *prior plan* has no extension of benefits when that plan terminates;
- the *treatment* expenses were incurred under the *prior plan*; and
- the *treatment* was completed while participating under this *Plan*.

Treatment Not Completed during Extension of Benefits

This *Plan* will pro-rate benefits according to the percentage of *treatment* performed while insured under the *prior plan* and during the extension if:

- the *prior plan* has an extension of benefits;
- the *treatment* expenses were incurred under the *prior plan*; and
- the *treatment* was not completed during the *prior plan*'s extension of benefits.

This *Plan* will consider only the percentage of *treatment* completed beyond the extension period to determine any benefits payable under this *Plan*.

ARTICLE THREE
COORDINATION OF BENEFITS

Applicability
All of the benefits provided under this Summary are subject to *this provision.*

This provision means the provision for coordination between the benefits of this *Plan* and other *programs*.

Order of Benefit Determination

The rules to establish the order of benefit determination for each *program* are as follows:

- A program which covers the claimant as an employee, member, or subscriber (that is, other than as a dependent) will determine its benefits before a program which covers the claimant as a dependent. However, if the claimant is also a Medicare beneficiary, and as the result of the rule established by Title XVIII of the Social Security Act and implementing regulations,
    - the *program* covering the *claimant* as a dependent will determine its benefits before *Medicare*; and
    - *Medicare* will determine its benefits before the *program* covering the *claimant* as other than a dependent (e.g. a retired employee). Then the *program* covering the *claimant* as a dependent will determine its benefits before the *program* covering the *claimant* as other than a dependent.

- In the event that the *claimant* is a dependent child whose parents are not divorced or separated, benefits for the child are determined in this order:
    - first, the *program* which covers the *claimant* as a dependent child of the parent whose birthdate occurs earlier in a calendar year; and
    - second, the *program* which covers the *claimant* as a dependent child of the parent whose birthdate occurs later in the calendar year.
    - If both parents have the same birthdate, benefits for the child are determined in this order:
        - first the *program* which covered the parent longer; and
        - second, the *program* which covered the other parent for a shorter period of time.

If the other *program* does not contain this exact rule regarding dependents, then this rule will not apply, and the rules set forth in the other *program* will determine the order of benefits.

- In the event that the *claimant* is a dependent child whose parents are divorced or separated, benefits for the child are determined in this order:
    - When the parent with custody of the child has not remarried:
        - first, the *program* which covers the child as a dependent of the parent with custody; and
        - second, the *program* which covers the child as a dependent of the parent without custody; or
    - When the parent with custody of the child has remarried:
        - first, the *program* which covers the child as a dependent of the parent with custody; and
        - second, the *program* which covers that child as a dependent of the stepparent; and
        - finally, the *program* which covers that child as a dependent of the parent without custody; or
    - When the parents have joint custody of the child and the court does not decree which parent is responsible for the health care expenses of the child, then benefits for the child will be determined according to the birthdate rule described above.
    - If the specific terms of a court decree that one parent is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the *program* of that parent has actual knowledge of these terms, then
        - first, the *program* of parent with financial responsibility; and
        - second, the *program* of the other parent.

      This does not apply to any *claim period* during which any benefits are actually paid or provided before the entity has that actual knowledge.
    - If the specific terms of a court decree state that both parents are responsible for the health care expenses of the child but gives physical custody of the child to a particular parent, then benefits for the child will be determined according to the birthday rule described above.

- A *program* which covers the *claimant* as a laid-off or retired employee, or as a dependent of that person, will determine its benefits after a *program* covering such *claimant* as an employee, other than a laid-off or retired employee, or as a dependent of that person.

  If a *program* does not have a provision regarding laid-off or retired employees, which results in each *program* determining its benefits after the other, then this rule will not apply.

- When the *claimant* whose coverage is provided under a federal or state continuation law is also covered under another *program*, benefits are determined in this order:
  - first, the *program* which covers the *claimant* as an employee; and
  - second, the *program* which covers the *claimant* under a continuation law.

  If the other *program* does not have a provision regarding coverage provided under continuation laws, then this rule will not apply.

- When none the rules described above establish an Order of Benefit Determination, a *program* which has covered the *claimant* longer will determine its benefits before a *program* which has covered that *claimant* for a shorter period of time.

Effect on Benefits
A *primary program's* benefits are not reduced because of the existence of another *program*.

When there are more than two *programs*, this *Plan* may be a *primary program* to one or more other *programs* and may be a *secondary program* to a different *program(s)*.

When this *Plan* is a *secondary program*, benefits payable under this *Plan* will be reduced so that when they are added to the benefits payable under all other *programs*, they will not exceed the total *allowable expenses* incurred by the *Participant* or a *covered dependent* during the *claim period*. Benefits payable under any other *program* include the benefits that would have been payable had the claim for them been made. Except for Part A and Part B of *Medicare*, the *Participant* or *covered dependent* must actually be covered by the other *programs*.

The *Plan* will exclude the benefits payable under any *program* in determining the above reduction if:
- that other *program* contains a provision which requires it to determine its benefits after the benefits of this *Plan*, and
- the rules set forth in the Order of Benefit Determination require this *Plan* to decide the benefits of this *Plan* before the other *program*.

When a reduction is made, each benefit that would have been payable in the absence of *this provision* will be reduced proportionately or in some other manner which the *Dental Claims Administrator* considers fair. The reduced amount will be charged against any benefit limit of this *Plan* that may apply.

Right to Receive and Release Necessary Information
A *claimant* will furnish any information necessary to implement *this provision*. The *Dental Claims Administrator* may release or obtain any information, with respect to the *claimant*, which it deems necessary. This information may be released to or received from any insurer, other organization, or person. This may be done without the consent of or notice to the *claimant*. In so acting, the *Dental Claims Administrator* and *Plan* will be free from any liability.

Facility of Payment
When payments which should have been made under this *Plan*, by the terms of *this provision*, have been made under any other *programs*, the *Dental Claims Administrator* has the right to pay to any organization making the other payments any amounts it determines are due to satisfy the intent of *this provision*. Any amount paid in good faith will release the *Plan* from further liability for that amount.

Recovery of Payment
If the *Dental Claims Administrator* pays more than the maximum amount required to satisfy the intent of *this provision* at that time, the *Dental Claims Administrator* has the right to recover the excess paid. Recovery may be made from any persons to, or for, or with respect to whom the payments were made, or from any other insurers or organizations. This includes the reasonable cash value of any benefits provided as a service.

ARTICLE FOUR
CLAIM PROVISIONS FOR DENTAL

Filing of Claim
As a condition to the receipt of benefits, a *Participant* covered by the *Plan* who has a claim for benefits under the *Plan* must give written notice of such claim to the *Plan Administrator* on the application form specified by the *Plan Administrator* for that purpose. As a further condition to the receipt of benefits, a *Participant* must submit such notice of claim at any time before the end of 30 days after the date after any covered loss occurs, or within a reasonable time thereafter. The time limit for submitting a notice of claim is 90 days after the date of the loss. All applications for benefits under the *Plan* shall be submitted, with such information as the application shall require, to the *Dental Claims Administrator*. The application form must be completed by the *Participating Employer*, *claimant* and the *dentist* providing *dental treatment* to the *claimant*. The *preferred provider* will send notice of all dental expenses incurred under the *preferred provider option*.

Time of Payment of Claim
After the *Dental Claims Administrator* has reviewed the claim form and obtained any other information deemed necessary to render a decision on the claim, the *Dental Claims Administrator* shall notify the *claimant* within 30 days after receipt of all data necessary to recommend the acceptance or denial of the *claimant*'s claim. Unless circumstances beyond the control of the *Plan* require an extension of time for processing the claim such recommendation shall be made within 30 days after receipt of the claim form. Such an extension of time may not exceed 15 additional days and notice of the extension shall be provided to the *claimant* prior to the termination of the initial 30 day period indicating the special circumstances requiring the extension and the date by which a final decision on the claim is expected.

To decide the *Plan's* liability, the *Dental Claims Administrator* may require additional information, including, but not limited to:

- itemized bills,
- proof of benefits from other sources,
- proof that the *claimant* has applied for all benefits from other sources, and that the *claimant* has furnished any proof required to get them,
- a complete dental charting indicating extractions, missing teeth, fillings, prosthesis, periodontal pocket depths, orthodontic relationship and the dates work was previously performed, and
- preoperative x-rays, study models, laboratory and/or hospital reports.

To Whom Payable
If the *Participant* or *covered dependent* assigns dental benefits to the provider of the dental *treatment*, any benefits payable under the *Plan* will be paid directly to the provider. Otherwise, any benefits payable under the *Plan* will be paid to the *Participant*. After the *Participant's* death, the *Dental Claims Administrator* has the option to pay any benefits payable under the *Plan* to the *Participant's* Spouse; to the providers of the *treatment*; or to the *Participant's* estate.

Claim Denials
In the event any claim for benefits is denied, in whole or in part, the *Dental Claims Administrator* shall notify the *claimant* of such denial in writing and shall advise the *claimant* of the *Plan's* review and appeal procedure. The notice shall be written in a manner calculated to be understood by the *claimant* and shall contain:

- specific reasons for the denial;
- specific references to the *Plan* provisions on which the denial is based;
- a description of any information or material necessary for the *claimant* to perfect the claim;
- an explanation of why such information or material is necessary; and
- an explanation of the *Plan's* review and appeal procedure.

Discretion of Plan Administrator
The discretionary responsibility and authority to determine eligibility for participation in the *Plan* and to interpret *Plan* provisions and to determine whether a claim will be paid or denied rests solely with the *Plan Administrator*.

Appeal Procedure
If a claim is denied in whole or in part as recommended by the *Dental Claims Administrator* the following claims appeal procedure shall be observed:

- The *claimant*, or the *claimant*'s duly authorized representative, may appeal the denial by submitting to the *Plan Administrator* a written request for review of the claim within 180 days after receiving written notice of such denial from the *Dental Claims Administrator*. Failure by the *claimant* to submit a request for review within 180 days after receiving the denial of benefits shall constitute a waiver by the *claimant* of the right to appeal the decision. The *Plan Administrator* shall, upon the *claimant*'s request, give the *claimant* an opportunity to review relevant documents, other than legally privileged documents, in preparing such request for review.

- The request for review must be in writing and shall be addressed as follows: Sun Life Financial, P.O. Box 2940, Clinton, IA 52733-2940
- The request for review shall set forth all of the grounds upon which it is based, all facts in support thereof and any other matters which the *claimant* deems pertinent. The *Plan Administrator* or the *Dental Claims Administrator* may require the *claimant* to submit, at the expense of the *claimant*, such additional facts, documents, or other material as are necessary or advisable in conducting the review.
- The *Plan Administrator* shall act upon each request for review within 60 days after the *Plan Administrator* receives the request for review.
- In the event the *Plan Administrator* confirms the denial of the claim for benefits in whole or in part, written notice of the *Plan Administrator's* decision shall be given to the *claimant*. Such notice shall be written in a manner calculated to be understood by the *claimant* and shall contain the specific reasons for the denial.

Exhaustion of Administrative Remedies
No legal action for benefits under the *Plan* shall be brought unless and until the following has occurred:
- The *claimant* has submitted a proper written claim for benefits;
- The *claimant* has been notified by the *Dental Claims Administrator* that the claim is denied.
- The *claimant* has filed a written appeal with the *Plan Administrator* for review of the denied claim as recommended by the *Dental Claims Administrator*.
- The *claimant* has been twice notified in writing of the *Plan Administrator's* decision to uphold the denial or the *Plan Administrator* has failed to take any action on the second request for review within the time prescribed by the terms of the *Plan*.

Required Physician Examination
The *Dental Claims Administrator* or *Plan Administrator* may require the *claimant* to submit to a medical examination, to be paid for by the *Plan*, by a *doctor or dentist* selected by the *Dental Claims Administrator* or *Plan Administrator* upon submission of a claim for benefits or appeal thereof under the *Plan*.

General Right to Receive and Release Necessary Information
Subject to federal and state law requirements, the *Dental Claims Administrator* and *Plan Administrator* may, for the purpose of determining a *claimant*'s qualification for an amount of benefits, and without the specific consent of any person, release to, or obtain from, any person, any information with respect to any person which the *Dental Claims Administrator* or *Plan Administrator* reasonably deems to be necessary for such purpose. Any *employee* shall furnish such information as the *Dental Claims Administrator* or *Plan Administrator* reasonably deems to be necessary to administer the *Plan*.

Overpayment and Subrogation Rights
The overpayment and subrogation provisions of the main SPD apply to dental benefits.