A Guide to Your DENTAL BENEFITS

Contractors Laborers Teamsters & Engineers

Dental

(Effective Date: 01/01/2024)

98-735 1/2024

IMPORTANT TELEPHONE NUMBERS

Member Services
Omaha and Toll-free 1-844-201-0763

Coordination of Benefits
Omaha 402-390-1840
Toll-free 1-800-462-2924

Subrogation
Omaha 402-390-1847
Toll-free 1-800-662-3554

Workers' Compensation
Omaha 402-398-3615
Toll-free 1-800-821-4786

Locating a Provider
Omaha and Toll-free 1-844-201-0763
Website . . . . . www.NebraskaBlue.com

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INTRODUCTION

Welcome

This document is your Summary Plan Description (SPD). It describes the benefits, exclusions and limitations of your Plan in a general way, and is not, and should not be considered a contract.

Your Group Dental Plan is administered in accordance with the Administrative Services Agreement between the Group and Blue Cross and Blue Shield of Nebraska (BCBSNE), an independent licensee of the Blue Cross and Blue Shield Association. The Administrative Services Agreement and official Plan documents control the coverage for your Group.

NOTE: BCBSNE provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. BCBSNE liability may occur only under a stop loss provision, as set forth in the Administrative Services Agreement.

How To Use This Document

For your convenience, defined terms are capitalized throughout this document. For an explanation of a defined term, refer to the Section titled "Definitions."

Please take some time to read this document and become familiar with it. As you read this document you will find that many sections are related to other sections of the document. You may not have all the information you need by reading just one section. We encourage you to review the benefits and limitations by reading the Schedule of Benefits Summary and the section titled "Exclusions."

If you have questions about your coverage or a claim, please contact BCBSNE Member Services Department at the number shown on your identification card.

About Your I.D. Card

BCBSNE will issue you an identification card (I.D. card). Your I.D. number is a unique alpha numeric combination.

Present your I.D. Card to your dental provider when you receive Services. With your BCBSNE I.D. card, most dentists and physicians can identify your coverage and will usually submit their claims for you.

If you want extra cards for covered family members or need to replace a lost card, please contact BCBSNE Member Services Department, or you may access through the website, www.nebraskablue.com.

Schedule Of Benefits

Your Schedule of Benefits is a personalized document sent by BCBSNE that provides you with a basic description of your coverage. It also shows the membership option that applies to you.

The Schedule of Benefits Summary is included in this SPD. It includes information concerning Deductible and Coinsurance amounts, benefit limits, and coverage details. For information which may be unique to your coverage, please refer to the Schedule of Benefits Summary.

THE DENTAL PLAN AND HOW IT WORKS

Section 1

About The Plan

This Group Dental Plan is a Preferred Provider Organization (PPO) dental benefit plan. Claims administration is provided by Blue Cross and Blue Shield of Nebraska (BCBSNE).

BCBSNE has contracted with a panel of Dentists and Physicians to establish a network of Providers who have agreed to furnish services to you and your family in a manner that will help manage costs. These providers are referred to as "In-network Providers."

Use of the network is voluntary, but you should be aware that when you choose to use providers who do not participate in the network, you can expect to pay more than your applicable Deductible and/or Coinsurance. After this dental plan pays its required portion of the bill, Out-of-network Providers may bill you for any amount not paid. This balance billing does not happen when you use In-network Providers because these providers have agreed to accept a discounted payment for services with no additional billing to you other than your applicable Deductible and/or Coinsurance. In-network Providers will also file claims for you.

If the Out-of-network Dentist is participating with us under another BCBSNE program, payment will be made pursuant to that particular program. The Dentist will be reimbursed based on the lower of the Out-of-network Allowance or billed charges. After this plan pays its liability, you can expect to pay your applicable Out-of-network Deductible and/or Coinsurance. You will also be responsible for payment of any Noncovered Services.

How the Network Works

Using Network Providers:

- Receive highest level of benefits
- Provider files claims for you
- Provider accepts insurance payment as payment in full (except Deductible and /or Coinsurance amounts)
- No balance billing

Using Out-of-network Providers:

- You may be required to pay full cost at time of service
- You may be reimbursed at a lower benefit level
- You may have to file claims
- You're responsible for amounts that exceed the Allowable Charge

Be Informed

Out-of-network Providers' charges may be higher than the benefit amount allowed by this dental plan. You may contact BCBSNE Member Services Department concerning allowable benefit amounts in Nebraska for specific dental procedures.

Categories Of Dental Coverage

There are five major categories of dental coverage. Your dental coverage is dependent upon which types of coverage your employer has chosen for your group dental plan. The types of dental coverage that you are enrolled under are indicated on your Schedule of Benefits Summary.

The five categories of dental coverage are:

- Coverage A (Preventive and Diagnostic Dentistry)
- Coverage B (Maintenance and Simple Restorative Dentistry, Oral Surgery, Periodontic and Endodontic Services)
- Coverage C (Complex Restorative Dentistry)
- Coverage D (Orthodontic Dentistry)
- Coverage E (Temporomandibular [Jaw] Joint Diagnosis and Treatment)

These categories are described in more detail on your Schedule of Benefits Summary.

The dental benefits available to you work together to provide your dental care program. How benefits are provided depends on whether the dental service or treatment falls under Type A, B, C, D or E coverage.

How The Plan Components Work

Your Deductible and Coinsurance are shown on your Schedule of Benefits Summary. The following includes an explanation of each of those components.

Allowable Charge – An amount BCBSNE uses to calculate the payment of Covered Services. This amount will be based on either the Contracted Amount for In-network Providers or the Out-of-network Allowance for Out-of-network Providers.

Coinsurance – This is the percentage you must pay for Covered Services, after any applicable Deductible.

Deductible – You are responsible for certain expenses until you reach the Plan's Deductible, as shown on your Schedule of Benefits Summary. After the Deductible is met, benefits for Covered Services will not be subject to any further Deductible for the rest of that Benefit Year.

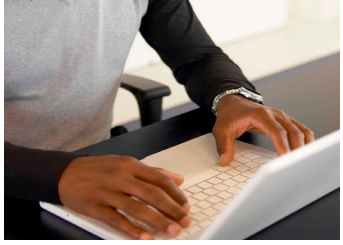
Maximum Benefits –Your Schedule of Benefits Summary will tell you if you have a benefit maximum for one or more types of dental coverage and/or an overall dollar maximum benefit for one or more types of dental coverage.

Not Medically Necessary Services – Benefits are available under this dental plan for Medically Necessary Services. Services provided by all providers are subject to review by BCBSNE. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Dentist or Physician. BCBSNE will determine whether Services provided are Medically Necessary under the terms of the Group Dental Plan, and whether benefits are available. When an In-network Provider is used, you are not responsible for Services determined to be not Medically Necessary. When Out-of-network Providers are used, you will be responsible for Services determined to be not Medically Necessary.

Certification – Certification (Preauthorization) procedures are intended to determine if Services or supplies are appropriate according to the terms of the Group Dental Plan. If Certification is required for certain Services, it will be shown on your Schedule of Benefits or stated in this SPD. A Dentist or Physician may also submit a Certification request to obtain a pre-treatment estimate of benefits.

Written requests for Certification should be submitted to the address on the back of your I.D. card. Certification does not guarantee payment, all other Plan provisions apply, for example cost-sharing, eligibility and exclusions.

If Services are not properly Certified by BCBSNE, when required, benefits may be reduced and/or you may be responsible for unanticipated costs associated with the incurred expenses.



SCHEDULE OF BENEFITS SUMMARY

Section 2

Payment for Services	In-Network Provider	Out-of-Network Provider
BlueCross and BlueShield of Nebraska In-Network Providers have agreed to accept the benefit payment as payment in full, until the In-Network Calendar Year maximum has been met. Out-of-network providers will be paid as billed until the Out-of-Network Calendar Year maximum has been met. In and Out of Network amounts cross accumulate.		
Calendar Year Maximum Benefit (Plan Pays 100% up to Calendar Year Maximum Benefit per member)	**$2,400**	**$1,200**
All services provided by a Dentist are covered, subject to the Calendar Year Maximum, as outlined below.		
COVERED DENTAL SERVICES		
Coverage A (Preventive and Diagnostic)	0% Coinsurance	0% Coinsurance
Coverage B (Maintenance, Simple Restorative and Oral Surgery)	0% Coinsurance	0% Coinsurance
Coverage C (Complex Restorative, Periodontics and Endodontics)	0% Coinsurance	0% Coinsurance
Coverage D (Orthodontic Dentistry)	0% Coinsurance	0% Coinsurance
Coverage E (TMJ Services)	Not Covered under Dental	Not Covered under Dental

Please note: This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.

Your employer determines eligibility requirements and validates eligibility for enrollment and coverage under the dental Plan. For additional information not found in this Summary Plan Description, please contact your employer.

Active Participants Eligibility

Who's Eligible
An employee will become eligible on the first day of the calendar month following the month in which he/she had a minimum of 500 hours of employment credited to his/her account by a contributing employer or employers within a continuous 5 month period.

Continuation of Eligibility
Once having become eligible, to remain eligible an employee must be credited with contributions in the amount of 300 hours in the first three months of the five months immediately preceding the month in which his/her claim arises or 1200 hours in the first 12 months of the last 14 months immediately preceding the month in which his/her claim arises. This rule will not apply if the employee has been ineligible for 12 consecutive months or longer. In that event, the employee will be required to reinstate his/her eligibility.

Maintenance Of Eligibility Of Employees Receiving Disability Benefits
An employee of a participating employer who is eligible and is receiving disability benefits under this Plan, or who is eligible and entitled to benefits under any Workers' Compensation or Occupational Disease Law, shall, beginning with the eighth day of his/her disability, receive 21 hours of contribution credit for each week he/she is entitled to or is receiving such benefits. This contribution credit accumulation will cease when said benefits cease or when such contribution credits total 250 hours, whichever occurs first.

Note: Questions regarding eligibility or hours worked can be referred to the CLT&E Fund Office.

Reinstatement Of Eligibility
In the event an individual remains ineligible for twelve (12) consecutive months, he/she will be required, in order to reestablish eligibility, to comply with the requirements of the Eligibility Provisions stated above.

Employment Outside Of Jurisdiction
A Contributing Employer may continue to contribute for his/her eligible employees even though doing work outside the territorial jurisdiction of the applicable Collective Bargaining Agreement, provided the contributing employer continues to be recognized as such by the Trustees, and contributes on each man hour worked.

Dependent Eligibility
Your spouse and children may be enrolled provided that they meet the definition of an Eligible Dependent.

Effective Date of Coverage
For additional information on adding a dependent, including any documentation that is required by the Plan, please contact the CLT&E Fund Office.

Types of Membership

You may enroll in one of the following membership types under your Plan:

- Single Membership: This option provides coverage to you only.
- Family Membership: This option provides coverage to you, your spouse and Eligible Dependent children.

NOTE: If two eligible persons in the same employer group are married to each other, each person and/or their Eligible Dependents may not enroll under more than one membership unit. Also, if two eligible persons have a parent/child relationship and both are employed by the same employer Group, the parent and child may elect to enroll either as two employees, or the parent may enroll as an employee with dependent coverage.

Special Enrollment

A period of 31 days is allowed for:

- enrollment of eligible persons due to marriage, birth, adoption or placement for adoption;
- enrollment of eligible persons not previously covered under this plan due to having had other coverage at the time it was previously offered, and who have lost that other coverage due to:
  - exhaustion of COBRA continuation coverage; or
  - a loss of eligibility, including loss due to death, divorce, legal separation, termination of employment or reduction in hours, or due to the plan no longer offering benefits to the class of individuals that includes the person (when the other coverage was not COBRA); or
  - moving out of the service area of an HMO or other arrangement that only provides benefits to individuals who reside, live or work in the service area; or
  - the lifetime limit on all benefits is exhausted; or
  - the employer ceasing to make contribution for the other coverage (when the other coverage was not COBRA).

A special enrollment period of 60 days is allowed for:

- Enrollment of eligible persons who were covered under Medicaid or State Child Health Insurance Program (SCHIP), which has been terminated due to loss of eligibility.
- Enrollment of eligible persons who have become eligible for premium assistance for this group health plan coverage under Medicaid or SCHIP.

The Subscriber must enroll (or already be enrolled) in order to enroll his or her dependents in this plan. In the case of a marriage, birth or adoption, a Subscriber who is eligible, but who has not previously enrolled, may enroll at this time with or without the newly Eligible Dependent. Likewise an otherwise Eligible Dependent who has not previously enrolled, may enroll as a Special Enrollee with or without a new dependent child. Please contact your Human Resource Department for additional information.

Dental Late Enrollment

Employees and dependents whose dental enrollment forms are not received within 31 days of their eligibility, are considered "late enrollees." A late enrollee is not eligible to apply for dental coverage until the next Annual Enrollment Month which follows the employee's eligibility date, unless BCBSNE approves a special enrollment period. Dental coverage for the first year following the Annual Enrollment Month will be limited to Coverage A only and premiums will not be reduced. A person who enrolls for coverage during a "special enrollment period" is not considered a "late enrollee."

Adding A Dependent

Dependents cannot enroll unless you, the eligible employee, are covered under the Plan. In order to add a dependent, he or she must meet the definition of an Eligible Dependent. Please contact the CLT & E Fund office for enrollment information and instructions.

Effective Date of Coverage

Provided that an appropriate membership option is in place and, if applicable, any additional premium is paid, the effective date of coverage will be as follows:

Marriage: The first day of the month following receipt of the enrollment form.

Newborn Children: Coverage will begin at birth for your newborn child for a period of 31 days. To continue coverage, you must enroll the child within that 31-day period. If your spouse was not enrolled at the time of the child's birth, he or she may also enroll within this 31-day period, and the effective date of coverage will be the date of the child's birth.

For additional information on adding newborn children, please contact your Human Resource Department.

Adopted Children: Coverage for an adopted child will be effective on the earlier of the date the child is placed with you for adoption, or the date a court order grants custody to you. You must enroll the child within 31 days of the placement or custody order. If your spouse was not enrolled at the time of the adoption, he or she may also enroll within this 31-day period, and the effective date of coverage will be the date of the placement/adoption.

Loss of Other Coverage: The effective date of coverge for persons enrolling as a special enrollee following a loss of other coverage will be no later than the first day of the month following the loss of other coverage.

Qualified Medical Child Support Orders (QMCSO)

A QMCSO is a court order that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or paternity disputes. The order may direct the Group Dental Plan to enroll the child(ren), and also creates a right for the alternate recipient to receive plan information, submit claims and receive benefits for services.

QMCSOs are specifically defined under the law, and are required to include certain information in order to be considered "qualified." A National Medical Support Notice received by the employer or Group Dental Plan from a state agency, regarding coverage for a child, will also be treated as a QMCSO. The Plan Administrator or its designee, will review the Order or Notice to determine whether it is qualified, and make a coverage determination. The Plan Administrator or its designee will notify affected employees and the alternate recipient(s) if a QMCSO is received.

You have the right to request a copy of the Group Dental Plan's procedures governing QMCSO determinations from the Plan Administrator, at no charge.

Active Employees Age 65 And Over

Federal law affects the way employers provide coverage to eligible active employees and their spouses who are 65 and over. These active employees and their spouses ages 65 and over may elect to continue full benefits under the employer group benefit plan or choose Medicare as their primary coverage. If the group plan is elected as the primary carrier (the plan which pays first), Medicare becomes the secondary coverage. If Medicare is elected as the primary carrier, coverage under the group plan, including dental coverage, will be terminated.

Family Medical Leave Act (FMLA)

The Family Medical Leave Act of 1993, as amended, requires that subject to certain limitations, most employers of 50 or more persons must offer continued coverage to eligible employees and their covered dependents, while the employee is on an approved FMLA leave of absence. In addition, an employee who has terminated his/her group dental coverage while on an approved FMLA leave is entitled to reenroll for group dental coverage upon return to work. Please check with your employer for details regarding your eligibility under FMLA.

If You Receive Covered Services From An In-network Provider

Contracting Providers and many other Dentists and Physicians will file the Claim to BCBSNE on your behalf. When BCBSNE receives a Claim from a Contracting Provider, payment will be made directly to that Provider, unless otherwise provided by state of federal law. You are responsible for meeting any applicable Deductible and Coinsurance amounts. You may be asked to pay amounts that are your liability at the time of service, or the provider may bill you for those amounts.

Filing A Claim

You must file your own claim if your dental care provider is not a Contracting Provider and does not file for you. You can obtain a claim form by contacting BCBSNE's Member Services Department, or you can find a form on the website: www.nebraskablue.com.

All submitted claims must include:

- correct I.D. number, including the alpha prefix;
- name of patient;
- the exact date and time of an accident (if applicable) and whether or not it occurred at work.;
- the original, itemized dental bill, including the date of service, description and charge for the service;
- complete name, address and credentials (DDS, MD) of the provider;
- the name and identification number of other insurance; and
- the primary plan's explanation of benefits (EOB), if applicable.

Claims cannot be processed if they are incomplete, and may be denied for "lack of information" if required information is not received.

Claims should be filed as soon as possible after services are provided. If a claim is not filed within the claim filing limit (normally within 15 months of the date of service), benefits will not be allowed. Claims, including revisions, that are not filed by a BCBSNE In-network Provider prior to the claim filing limit, will become the provider's liability.

Claim forms should be sent to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, Nebraska 68180-0001

If you need assistance with filing your claim, please contact BCBSNE's Member Services Department.

Payment Of Benefits For Non-Contracting Provider Claims

Payment will be made, at BCBSNE's option, to the Covered Person, to his or her estate, to the provider or as required by state or federal law. Benefits may also be paid to an alternate recipient or custodial parent, if pursuant to a QMCSO.

No assignment, whether made before or after Services are provided, of any amount payable according to this group benefit plan shall be recognized or accepted as binding upon BCBSNE, unless otherwise provided by state or federal law.

Right to Amend Provider Agreements Or Benefit Payment Procedures

Agreements with health or dental care providers may be changed or terminated, and benefit payments to In-network Providers may be altered. Benefit payments may be calculated on a charge basis, a Contracted Amount or similar charge, global fee basis, through a Preferred Provider Organization, or in any other manner agreed upon by BCBSNE or the On-site Plan and the provider. However, any payment method agreed upon will not affect the method of calculating the Deductible and Coinsurance.

Claim Determinations

A "Claim" may be classified as a "Preservice" or "Postservice".

Preservice Claims — In some cases, under the terms of the Group Dental Plan, the Covered Person is required to certify benefits in advance of a Service being provided, or benefits for the Service may be reduced or denied. This required request for a benefit is a "Preservice" Claim." Preservice Claim determinations that are not Urgent Care Claims will be made with 15 calendar days of receipt, unless an extension is needed to obtain necessary information. If additional information is requested, the Covered Person or his or her provider may be given up to 45 calendar days from receipt of notice to submit the specified information. A Claim determination will be made within 15 days of receipt of the information, or the end of the 45 day extension period.

Urgent Care — If your Preservice Claim is one for Urgent Care, the determination will be made within 72 hours of receipt of the claim, unless further information is needed. If additional information is necessary, the Covered Person or his or her provider will be given no less than 48 hours to provide the specified information. Notification of the decision will be provided not later than 48 hours after the earlier of: our receipt of the information, or the end of the period allowed to submit the information.

Postservice Claims — A Postservice Claim is any Claim that is not a Preservice Claim. In most cases, a Postservice Claim is a request for benefits or reimbursement of expenses for medical care that has been provided to a Covered Person. The instructions for filing a Postservice Claim are outlined earlier in this section. Upon receipt of a completed claim form, a Postservice Claim will be processed within 30 days, unless additional information is needed. If additional information is requested, the Covered Person may be given not less than 45 days to submit the necessary information. A Claim determination will be made within 15 days of receipt of the information, or the expiration of the 45-day extension period. You will receive an EOB when a Claim is processed which explains the manner in which your claim was handled.

Concurrent Care — If you request to extend a course of treatment beyond the care previously approved and it involves urgent care, a decision will be made within 24 hours of the request, if you submitted the request at least 24 hours before the course of treatment expires. In all other cases, the request for an extension will be decided as appropriate for a Preservice and Postservice Claims.

Explanation Of Benefits

Every time a claim is processed for you, an Explanation of Benefits (EOB) form will be sent. The front page of the EOB provides you with a summary of the payment including:

- the patient's name and the claim number.
- the name of the individual or institution that was paid for the service.
- the total charge associated with the claim.
- the covered amount.
- any amount previously processed by this plan, or another insurance company.
- the amount(s) that you are responsible to pay the Provider.
- the total Deductible, Coinsurance that you have accumulated to date.
- other general messages.

A more detailed breakdown of the charges including provider discounts, amount paid and cost sharing amounts (e.g. noncovered charges, Deductible, Coinsurance and Copays) are shown on the back of your EOB.

Also included on your EOB is information regarding your right to appeal a benefit determination, or request additional information.

Save your EOBs in the event that you need them for other insurance or for tax purposes.

APPEAL PROCEDURES

Section 6

BCBSNE has the discretionary authority to determine eligibility for benefits under the dental Plan, and to construe and interpret the terms of the Plan, consistent with the terms of the Administrative Services Agreement.

You have the right to seek and obtain a review of "adverse benefit determinations" arising under this Plan.

Appeal Procedure Definitions

Adverse Benefit Determination: A determination by BCBSNE or its Utilization Review designee, of the denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) of a benefit. This includes any such determination that is based on:

- the application of Utilization Review;
- a determination that the Service is Investigative;
- a determination that the Service is not Medically Necessary or appropriate;
- an individual's eligibility for coverage or to participate in a plan.

An Adverse Benefit Determination also includes any rescission of coverage, which is defined as a cancellation or discontinuance of coverage that has a retroactive effect, except if for failure to timely pay required premiums or contribution for coverage.

Final Internal Adverse Benefit Determination: An Adverse Benefit Determination that has been upheld by BCBSNE, or its Utilization Review designee, at the completion of the internal appeal process as described in this document.

Preservice Claim(s): Any Claim for a benefit under the Plan with respect to which the terms of the Contract require approval of the benefit in advance of obtaining medical care, and failure to do so will cause benefits to be denied or reduced.

Postservice Claim(s): Any Claim that is not a Preservice Claim.

Urgent Care Claim: A Claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations:

- could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or
- would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

How To Appeal An Adverse Benefit Determination

A Covered Person or a person acting on his/her behalf (the "claimant") is entitled to an opportunity to appeal initial or final Adverse Benefit Determinations.

Internal Appeal

A request for an internal appeal must be submitted within 6 months of the date the Claim was processed, or Adverse Benefit Determination was made. The written request for an appeal should state that it is a request for an appeal and, if possible, include a copy of the Explanation of Benefits (EOB). The appeal should also include:

- the name of the person submitting the appeal and his/her relationship to the patient;
- the reason for the appeal;
- any information that might help resolve the issue; and
- the date of service/Claim.

The written appeal should be sent to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, Nebraska 68180-0001

The claimant does not have the right to be in attendance at the appeal review nor to have a representative in attendance, but may submit additional information for consideration.

If the Adverse Benefit Determination was based on a medical judgment, including a Medical Necessity or Investigative determination, BCBSNE will consult with professionals with appropriate training and experience in the field of medicine involved in the medical judgment, to make the appeal determination. The appeal determination will be made by individuals who were not involved in the original determination.

Preservice or Postservice Claim Appeal: A written notice of the appeal determination will be provided to the claimant as follows:

- Preservice Claims (other than Urgent Care), within 30 calendar days after receipt.
- Postservice Claims, within 60 calendar days after receipt.

Expedited Appeal: When the appeal is related to an Urgent Care Claim, an expedited appeal may be requested. In the case of an expedited appeal, the request may be submitted in writing or orally. All information, including the decision, will be submitted by telephone, facsimile or the most expeditious method available. BCBSNE will make an expedited review decision within 72 hours after the appeal is received. Written notification of the decision will be sent within the 72-hour period.

Concurrent Care: A request for an expedited appeal of a concurrent care denial must be made within 24 hours of the denial. If the appeal is requested within the 24-hour time period, coverage will continue for Services pending notification of the review decision, as may be required by law. The decision time frame will be the same as for other expedited appeals.

The decision made pursuant to this appeal will be considered a Final Adverse Benefit Determination.

NOTE: When an adverse appeal determination involves medical judgment, upon receipt of a written request, the identity of the professionals who reviewed the appeal will be provided to the claimant.

Rights To Documentation

A claimant has the right to have access to, and request copies of, the documentation relevant to the Claim and Adverse Benefit Determination(s), including any new evidence or rationale considered or relied upon in connection with the Claim on review.

The claimant may submit additional comments, documents or records relating to the Claim for consideration during the appeal process.

External Review

Standard External Review: If the claimant has exhausted internal appeal reviews, an external review by an Independent Review Organization (IRO) may be requested for review of an Adverse Benefit Determination or Final Internal Adverse Benefits Determination. The request must be submitted in writing within four months after the date of receipt of the Final Internal Adverse Benefit Determination. (An Adverse Benefit Determination based on an individual's eligibility for coverage or to participate in a plan is not eligible for External Review.)

Upon receipt of a request for an External Review, BCBSNE shall review the request to determine if it is complete and whether the request is eligible for External Review. BCBSNE will conduct the preliminary review within 5 business days of receipt, and notify the claimant of the outcome within one business day. If it is determined that the request is not complete, or it is not eligible for External Review, the claimant will be notified of the reason for ineligibility, or advised of the information needed to make the request complete.

If the request is eligible for External Review, it will be forwarded to the IRO, including the documentation and information considered in making the initial Adverse or Final Adverse Benefit Determination. The claimant will be allowed an opportunity to submit additional information for consideration by the IRO. The IRO shall provide BCBSNE with any information submitted by the claimant, to allow BCBSNE an opportunity to reconsider its original determination.

The IRO shall complete its review and provide the claimant written notification and rationale for its decision within 45 days of receipt of the request for review. No deference shall be given to the prior determinations made by BCBSNE pursuant to the internal appeal process.

Expedited External Review: An expedited External Review may be requested at the same time a claimant requests an expedited internal appeal of an Adverse Benefit Determination of an Urgent Care Claim. However, the claimant must first exhaust the internal appeal process unless otherwise waived by BCBSNE.

An expedited External Review may also be requested following a Final Internal Adverse Benefit Determination if:

- the Covered Person has a medical condition where the time frame for completion of a standard External Review would seriously jeopardize the life or health of the Covered Person, or would jeopardize his or her ability to regain maximum function; or
- the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay or health care Service for which the Covered Person has received emergency Services, but has not been discharged from the facility.

An expedited External Review decision shall be made by the IRO within 72 hours after receipt of the request.

The decision of the IRO is the final review decision and is binding on BCBSNE and the claimant, except to the extent that the claimant may have other remedies available under applicable federal or state law. Once an external review decision has been made, the Covered Person or his/her representative may not file a subsequent request for an external review involving the same initial or final Adverse Benefit Determination.

When You Have Coverage Under More Than One Plan

This Plan includes a Coordination of Benefits (COB) provision. COB provisions apply when a Covered Person has coverage under more than one health Plan. This provision establishes a uniform order in which the Plans pay their Claims, limits the duplication of benefits, and provides for transfer of information between the Plans.

The order of benefit determination rules described in this section determine which Plan will pay as the primary Plan without regard to any benefits that might be payable by another Plan.

Definitions

For the purpose of this section, the terms are defined as:

Allowable Expense: A health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical options, precertification of admissions, and preferred provider arrangements.

Closed Panel Plan: A Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent: The parent awarded custody by a court decree or, in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year excluding temporary visitation.

Plan: As used in this section, any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

a. Plan includes: group and nongroup insurance contracts and subscriber contracts, health maintenance organization (HMO) contracts, Closed Panel Plans; other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits coverage in automobile "no-fault" and traditional "fault" type contracts; group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; and Medicare or any other federal governmental Plan, as permitted by law.

b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined in state law; school accident coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; and coverage under other federal governmental Plans, unless permitted by law.

Each contract for coverage under a. or b. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

Primary Plan: The Plan that will determine payment for its benefits first before those of any other Plan without considering any other Plan's benefits.

Secondary Plan: The Plan that will determine its benefits after those of another Plan and may reduce the benefits so that all Plan benefits do not exceed 100% of the total Allowable Expense.

This Plan: The part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order Of Benefit Determination Rules

1. The Primary Plan pays or provides its benefits according to its terms or coverage and without regard to the benefits under any other Plan.
2. A Plan that does not contain a coordination of benefits provision that is consistent with this Part is always primary unless the provisions of both Plans stated that the complying Plan is primary.
3. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
4. Each Plan determines its order of benefits using the first of the following rules that apply:

Subscriber And Dependent: The Plan that covers the person as other than a dependent, such as a subscriber/policyholder/employee is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as a subscriber, then the order of benefits between the two Plans is reversed so that the Plan covering the person as a subscriber is the Secondary Plan and the other Plan is the Primary Plan.

Dependent Child Covered Under More Than One Plan: Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

For a dependent child whose parents are married or are living together, whether or not they have ever been married, the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan. If both parents have the same birthday, the Plan that has covered the parents the longest is the Primary Plan (birthday rule).

For a dependent child whose parents are divorced, separated or not living together, whether or not they have ever been married, if a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, the Plan of that parent's spouse is primary. This rule applies to Plan years beginning after the Plan is given notice of the court decree.

If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the order of benefits shall be determined by the "birthday rule" stated above.

If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the order of benefits shall be determined by the "birthday rule" stated above.

If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- the Plan covering the Custodial Parent;
- the Plan covering the spouse of the Custodial Parent;
- the Plan covering the non-custodial parent; and then
- the Plan covering the spouse of the non-custodial parent.

For a dependent child covered under more than one Plan of individuals who are not parents of the child, the above provisions shall apply as if those individuals were the parents.

For an Eligible Dependent child covered under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule below for "Longer or Shorter Length of Coverage" applies. In the event the Eligible Dependent child's coverage under the spouse's plan began on the same date as his or her coverage under the parents' plan(s), the order of benefits shall be determined by applying the "birthday rule" above, to the child's parent(s) and to his or her spouse.

Active Employee, Retired Or Laid-Off Employee: The Plan that covers a person as an active employee, that is, an employee who is neither retired nor laid off, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the first rule (Subscriber and Dependent) can determine the order of benefits.

COBRA Or State Continuation Coverage: If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as a subscriber/member/employee/retiree or covering the person as a dependent of a subscriber/member/employee/retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the first rule (Subscriber and Dependent) can determine the order of benefits.

Longer Or Shorter Length Of Coverage: The Plan that has covered the person longer is the Primary Plan and the Plan that has covered the person the shorter period of time is the Secondary Plan. The start of a new Plan does not include a change in the amount or scope of a Plan's benefits; a change in the entity that pays, provides or administers the Plan's benefits; or a change from one type of Plan to another, such as from a single employer Plan to a multiple employer Plan.

If the above rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Administration Of Coordination Of Benefits

The order of benefit determination rules govern the order in which each Plan will pay a Claim for benefits. The Plan that pays first is called the Primary Plan. The Plan that pays after the Primary Plan is called the Secondary Plan.

If This Plan is the Primary Plan, there shall be no reduction of benefits. Benefits will be paid without regard to the benefits of any other Plan.

If This Plan is the Secondary Plan, it may reduce its benefits so that the total benefits paid or provided by all Plans for any Claim are not more than the total Allowable Expenses. In determining the amount to be paid for any Claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the Claim do not exceed the total Allowable Expense for that Claim. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health coverage.

Miscellaneous Provisions

If these COB rules do not specifically address a particular situation, BCBSNE may, at its discretion, rely on the National Association of Insurance Commissioners Coordination of Benefits Model Regulation as an interpretive guide.

To properly administer these COB rules, certain facts are needed. This Plan may obtain or release information to any insurance company, organization or person. Any person who claims benefits under This Plan agrees to furnish the information that may be necessary to apply COB rules and determine benefits.

If another Plan pays benefits that should have been paid under This Plan, this Plan may reimburse the other Plan amounts determined to be necessary. Amounts paid to other Plans in this manner will be considered benefits paid under This Plan and This Plan is released from liability for any such amounts.

If the amount of the benefits paid by This Plan exceeds the amount it should have paid, This Plan has the right to recover any excess from any other insurer, any other organization, or any person to or for whom such amounts were paid, including Covered Persons under This Plan.

Termination of Coverage

Coverage under your group plan will terminate for you and/or your dependents on the earliest of the following dates:

- the date the entire Contract is terminated;
- the last day or the month in which you cease to be eligible under the dental plan; or a dependent ceases to be an Eligible Dependent;
- another date as specified by your employer.

NOTE: If an employee voluntarily cancels his/her dental coverage, the employee and his/her eligible dependents may not re-enroll for two years from the first month following the date of cancelation.

You and/or your Eligible Dependents may be eligible to continue coverage under the Group Dental Plan as detailed in this section.

Continuation Of Coverage Under The Federal Continuation Law

If you terminate your employment, or if a dependent loses coverage due to certain "Qualifying Events", continued coverage under the Group Dental Plan may be available. Payment for continued coverage under the federal continuation law is at the employee's or dependent's own expense. Please contact your employer for details regarding eligibility.

What Is The Federal Continuation Law?

The Consolidated Omnibus Reconciliation Act (COBRA), is a federal law which provides that a Covered Person who would lose coverage due to the occurrence of a "Qualifying Event", may elect to continue coverage under the Group Dental Plan. A person who is eligible to continue coverage is called a "Qualified Beneficiary." A Qualified Beneficiary also includes a child born to, or placed for adoption with the Covered Person during the period of COBRA coverage. Please share the information found in this section with your Eligible Dependents.

NOTE: To protect your rights under COBRA, please keep your employer informed of your current address.

Termination Of Employment Or Reduction In Hours – COBRA provides that if you should lose eligibility for coverage due to:

- voluntary or involuntary termination of employment (other than for gross misconduct) ;
- a lay-off for economic reasons; or
- a reduction in work hours

you and your covered dependents may be able to continue the group coverage at your own expense for up to 18 months. Your employer is required to notify the Plan Administrator within 30 days of the loss of coverage. The Plan Administrator will send the Qualified Beneficiaries a COBRA notification within 14 days after receiving notice from the employer. If the employer and Plan Administrator are the same entity, the COBRA notification will be sent within 44 days of the date of the loss of coverage.

Disability – If a Qualified Beneficiary is determined by the Social Security Administration to have been disabled any time during the first 60 days of COBRA continuation coverage, the COBRA coverage period for the disabled individual and his or her related beneficiaries may be extended to 29 months instead of 18 months when loss of coverage is due to termination or reduction in hours of employment. You must provide written notice of the disability determination to the plan within 18 months of becoming eligible for COBRA and no later than 60 days after the date of the Social Security Administration's determination.

If the Social Security Administration determines that you or the dependent are no longer disabled, the extended continuation of coverage period (19th through 29th month) will be terminated the month that begins more than 30 days after the determination. You must notify the plan within 30 days of a determination that an individual is no longer disabled.

Change In Dependent Status, Divorce/Separation Or Medicare Entitlement – COBRA requires that continued coverage under the Plan be offered to your covered spouse and eligible children if they would otherwise lose coverage as a result of:

- divorce or legal separation;
- a child losing dependent status, or
- the employee becoming entitled to Medicare.

When one of these circumstances occur, you or the dependent are obligated to notify the employer or Plan Administrator within 60 days. Failure to provide timely and proper notice may result in the loss of the right to COBRA.

After receiving a timely notice of such an event, your employer or the Plan Administrator will send the Qualified Beneficiary an election form and the information needed to apply for coverage, if eligible, within 14 days of the date the notice is received. Coverage may be continued at the individual's expense for up to 36 months.

Your Death – If you should die while you are covered under this Group Dental Plan, continued coverage is available to your spouse and Eligible Dependents.

COBRA provides that subject to certain limitations, your surviving spouse and children may continue the group dental coverage at their own expense for up to 36 months. Federal law requires your Plan Administrator to send the surviving family members instructions as to how to apply for continued coverage if they are eligible.

Special Provisions — If an employer files Chapter 11 bankruptcy, special provisions regarding COBRA continuation coverage may apply for a retiree or deceased retiree's surviving spouse and dependent children. Please check with your employer for details.

Electing COBRA Coverage

Qualified Beneficiaries will be sent a written notice of the right to continue health coverage and an election form(s).

Reminder: *In the case of a divorce or legal separation, or if a child loses dependent status, you must notify your employer or plan administrator of this Qualifying Event within 60 days. Failure to provide timely and proper notice may result in the loss of the right to COBRA coverage.*

Qualified Beneficiaries must complete and return the COBRA election form in order to continue coverage. The notice will include instructions for completing and returning the form. The election form must be received by the later of:

- 60 days after the day health coverage would otherwise end, or
- 60 days after the notice is sent to you by the employer or Plan Administrator.

COBRA continuation coverage may only begin on the day after coverage under the group plan would otherwise end. The required premium, including any retroactive premium, must be paid from the day coverage would have otherwise ended. The initial premium must be paid within 45 days after the day continued coverage is elected. Succeeding premiums must be paid monthly within 30 days of the premium due date. The COBRA notice and election form will inform you or your dependents of the monthly premium amount, and to whom such premium should be paid.

Second Qualifying Event — In the event your family experiences a second Qualifying Event while receiving an 18-month period of COBRA coverage (or the extended 29-month period), your covered spouse and dependents are eligible to extend the original COBRA coverage period to a maximum of 36 months if notice of the second event is properly given to the Plan Administrator. This extension may be available to the spouse and children receiving continuation coverage if: a) you die, b) you become entitled to Medicare, c) you get divorced or legally separated, or d) the dependent child is no longer eligible as a dependent, but only if the second event would have caused the spouse or child to lose coverage under the plan had the first Qualifying Event not occurred. In all of these cases, you or the dependent must notify the Plan Administrator, in writing, within 60 days of the second Qualifying Event. Failure to provide timely and proper notice may result in the loss of the right to extend COBRA coverage.

Termination Of COBRA Coverage

A Qualified Beneficiary's COBRA continuation coverage may be terminated at midnight on the earliest of:

- the day your employer ceases to provide any Group Dental Plan to any employee;
- the day the premium is due and unpaid;
- the day the individual first becomes covered under any other Group Dental Plan (after the COBRA election);
- the day the individual again becomes covered as an employee or dependent under the policy;
- the day an insured person becomes entitled to benefits under Medicare (after COBRA election); or
- the day dental insurance has been continued for the maximum period of time allowed (18, 29 or 36 months).

NOTE: *In the event more than one continuous provision applies, the periods of continued coverage may run concurrently, but never for more than 36 months.*

Benefit Plan Document

This document provides an overview of your benefits. It is not intended to be a complete description of every detail of the Plan. All coverage and benefit determinations are governed by the Benefit Plan Document, which consists of the Administrative Services Agreement, this SPD, and other documents entered into between the Group and BCBSNE.

Fraud Or Misrepresentation

A Covered Person's coverage may be canceled or rescinded for fraud or intentional misrepresentation of a material fact about a claim or eligibility for this coverage.

If coverage is rescinded, the amount of premium paid will be reduced by any benefits that were paid, and will be refunded. If benefits paid exceed premiums received, BCBSNE may recover the difference.

Contracting Providers

BCBSNE does not engage in the practice of medicine and all Contracting Providers provide Services under the terms of the Plan as independent practitioners of the healing arts. Such providers are not employees or agents of BCBSNE, or the On-site Plan, and BCBSNE will not be liable for any act, error, or neglect of any Hospital, Physician, Dentist or other provider or their agent, employee, successor or assignee.

Subrogation

Subrogation is the right to recover benefits paid for Covered Services provided as the result of Injury or Illness which was caused by another person or organization. When benefits are paid under the Group Plan, the Plan shall be subrogated to all of the Covered Person's right of recovery against any person or organization to the extent of the benefits paid. The Subscriber, the Covered Person or the person who has the right to recover for a Covered Person (usually a parent or spouse), agrees to make reimbursement to the Plan if payment is received from the person who caused the Illness or Injury or from that person's liability carrier.

This subrogation shall be a first priority lien on the full or partial proceeds of any settlement, judgement or other payment recovered by or on behalf of the Covered Person, whether or not there has been full compensation for all his or her losses or as provided by applicable state law. The Plan's rights shall not be defeated by allocating the proceeds in whole or in part to nonmedical damages.

Contractual Right To Reimbursement

If a Covered Person receives full or partial proceeds from any other source for Covered Services for an Illness or Injury, the Group Plan has a contractual right of reimbursement to the extent benefits were paid under the Plan for the same Illness or Injury. This contractual right to reimbursement shall be a first priority lien against any proceeds recovered by the Covered Person, whether or not the Covered Person has been fully compensated for all his or her losses, or as provided by applicable state law.

Such proceeds may include any settlement; judgment; payments made under group auto insurance; individual or group no fault auto insurance; another person's uninsured, under insured or medical payment insurance; or proceeds otherwise paid by a third party. This contractual right to reimbursement is in addition to and separate from the subrogation right. The Plan's rights shall not be defeated by allocating the proceeds in whole or in part, to nonmedical damages.

When proceeds are recovered under this contractual right to reimbursement for all or a part of the Claim, amounts previously credited to a Covered Person's Deductible or Coinsurance liability may be removed. Future Claims will be subject to the reinstated Deductible or Coinsurance.

No adult Subscriber may assign any rights to recover medical expenses from any third party to any minor or other dependent of the adult Subscriber or to any other person, without the express written consent of the Plan. The right to recover, whether by subrogation or reimbursement, shall apply to settlements or recoveries of deceased persons, minor dependents of a Subscriber, incompetent or disabled Subscribers, or their incompetent or disabled Eligible Dependents.

The Subscriber agrees to fully cooperate and assist in any way necessary to recover such payments, including but not limited to notifying BCBSNE of a claim or lawsuit filed on his or her behalf or on behalf of any Eligible Dependent for an Injury or Illness. The Subscriber, Eligible Dependent or an authorized representative shall contact BCBSNE prior to settling any claim or lawsuit to obtain an updated itemization of the subrogation Claim or reimbursement amount due. Upon receiving any proceeds, the Subscriber, Eligible Dependent or an authorized representative must hold such proceeds in trust until such time as the proceeds can be transferred to the Plan. The party holding the funds that rightfully belong to the Plan shall not interrupt or prejudice its recovery of such payments.

Costs incurred in enforcing these provisions shall also be recovered, including, but not limited to, attorneys' fees, litigation and court costs and other expenses.

Workers' Compensation

Benefits are not available for Services provided for Injuries or Illnesses arising out of and in the course of employment whether or not the Covered Person fails to assert or waives his or her right to Workers' Compensation or Employer Liability Law. The employer is required to furnish or pay for such Services or a settlement can be made, pursuant to Workers' Compensation laws. (See also the section of this book titled "Exclusions — What's Not Covered")

If a Covered Person enters into a lump-sum settlement which include compensation for past or future dental expenses for an Injury or Illness, payment will not be made under the Group Dental Plan for Services related to that Injury or Illness.

Benefits are not payable for services determined to be not compensable due to noncompliance with terms, rules and conditions under Workers' Compensation laws, or in a Certified or otherwise Licensed Workers' Compensation Managed Care Plan. In addition, benefits are not payable for Services that are related to the work Injury or Illness, but are determined to be not necessary or reasonable by the employer or Workers' Compensation carrier.

In certain instances, benefits for such Services are paid in error under the group plan. If payment is received by the Covered Person for such Services, reimbursement must be made. This reimbursement may be refunded from any recovery made from the employer, or the employer's Workers' Compensation carrier, as permitted by law. Reimbursement must be made directly by the Subscriber when benefits are paid in error due to his or her failure to comply with the terms, rules and conditions of Workers' Compensation laws or a Certified or Licensed Workers' Compensation Managed Care Plan.

Legal Actions

The Subscriber cannot bring legal action to recover for at least 60 days after written proof of loss is given to BCBSNE. The Subscriber cannot start a legal action after three years from the date written proof of loss is required.

Your ERISA Rights

AS a participant in this Group Plan, you are entitled to certain rights and protections under Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:

- Receive information about your plan and benefits:
  - examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plan, including insurance contracts, and collective bargaining agreements, and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
  - obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report and updated Summary Plan Description (SPD). The Plan Administrator may make a reasonable charge for the copies;
  - receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report;
- Continue Group coverage:
  - continue coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event (COBRA). You or your dependents may have to pay for such coverage. Review your SPD and the documents governing the plan for the rules regarding your COBRA continuation rights.

DEFINITIONS

Section 10

Accident: An unexpected occurrence that results in injury, loss or damage such as a fall or auto accident. Fractures of teeth due to eating, biting or chewing are not considered Accidents.

Administrative Services Agreement (ASA): The agreement entered into between the Group and BCBSNE for administration of the Group's self-insured, or partially self-insured, health care programs for eligible employees.

Allowable Charge: An amount BCBSNE uses to calculate payment of Covered Services. This amount will be based on either the Contracted Amount for In-network Providers or the Out-of-network Allowance for Out-of-network Providers.

Annual Enrollment Month: The month during which membership additions and deletions are made. This month usually corresponds to the rating anniversary and must be mutually agreed upon by the Group Applicant and BCBSNE.

Approved Provider: A licensed practitioner of the healing arts who provides Covered Services within the scope of his or her license and who is payable according to the terms of the Contract, Nebraska law and the direction of BCBSNE.

Benefit Plan Document: The agreement between BCBSNE and the Group which includes the Administrative Services Agreement and any attachments or addenda, this Summary Plan Description, and the individual enrollment information of Subscribers and their Eligible Dependents.

Certification (Certified): Successful voluntary compliance with certain prerequisite qualifications specified by regulatory entities.

Coinsurance: The percentage amount the Covered Person must pay for Covered Services, based on the lesser of the Allowable Charge or the billed charge.

Consultation: Dental services for a patient in need of specialized care requested by the attending Dentist who does not have that knowledge.

Contracted Amount: The payment agreed to by BCBSNE or an On-site Plan and contracting Providers for Covered Services received by a Covered Person.

Cosmetic: Any services provided to improve the patient's physical appearance, from which no significant improvement in physiologic function can be expected, regardless of emotional or psychological factors.

Covered Person: Any person entitled to benefits for Covered Services pursuant to the Benefit Plan Document administered by BCBSNE.

Covered Services: Dental procedures, supplies, drugs, or other dental care services, for which benefits are payable under the Benefit Plan Document, while the ASA is in effect.

Deductible: An amount of Allowable Charges which must be met for the Covered Person each Calendar Year for Covered Services before benefits are payable by the Plan.

Dentist: Any person who is appropriately Licensed and qualified to practice dentistry under the law of the jurisdiction in which the dental procedure is performed and is operating within the scope of his/her license.

Eligible Dependent:

1. The spouse of the Subscriber unless the marriage has been ended by a legal, effective decree of dissolution, divorce or separation.
2. Children to age 26.
   "Children" means:
   - the Subscriber's biological and adopted sons and daughters,
   - a grandchild who lives with the Subscriber in a regular child-parent relationship where the grandchild receives no support or maintenance from the parent and where the Subscriber is a court-appointed guardian of the grandchild,
   - a stepchild (i.e. the son or daughter of the Subscriber's current spouse), or
   - a child, other than a grandchild or stepchild, for whom the Subscriber is a court-appointed guardian, but does not include a foster child.
3. Reaching age 26 will not end the covered child's coverage under the Plan as long as the child is, and remains, both:
   a. incapable of self-sustaining employment, or of returning to school as a full-time student, by reason of mental or physical handicap; and
   b. dependent upon the Subscriber for support and maintenance.

Proof of the requirements of paragraphs a. and b. from the Subscriber must be received within 31 days of the child's reaching age 26 and after that, as required (but not more often than yearly after two years of such handicap). Determination of eligibility under this provision will be made by BCBSNE. Any extended coverage under this paragraph will be subject to all other provisions of the Plan.

General Anesthesia: A controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including loss of ability to independently maintain airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non pharmacologic method or combination thereof.

Gingivectomy: The excision or removal of gingival tissue.

Group: The employer or entity making providing dental coverage for its employees/participants pursuant to the agreement with BCBSNE.

Hospital: An institution or facility duly Licensed by the State of Nebraska or the state in which it is located, which provides medical, surgical, diagnostic and treatment Services with 24-hour per day nursing Services, to two or more nonrelated persons with an Illness, Injury or pregnancy, under the supervision of a staff of Physicians Licensed to practice medicine and surgery.

Illness: A condition which deviates from or disrupts normal bodily functions or body tissues in an abnormal way, and is manifested by a characteristic set of signs or symptoms.

Implant: An artificial material grafted or implanted into or on bone.

Injury: Physical harm or damage inflicted to the body from an external force.

In-network Provider: A health care provider (Physician, Dentist, or other health care provider) who has contracted with BCBSNE to provide services as a part of the Preferred Provider network in Nebraska.

Investigative: A technology, a drug, biological product, device, diagnostic, treatment or procedure that has not been Scientifically Validated. BCBSNE will determine whether a technology is Investigative.

Late Enrollee: An individual who does not enroll for coverage during the first period in which he or she is eligible, or during a special enrollment period.

Licensure (Licensed): Permission to engage in a health profession that would otherwise be unlawful in the state where services are performed, and which is granted to individuals who meet prerequisite qualifications. Licensure protects a given scope of practice and the title.

Medicaid: Grants to states for Medical Assistance Programs, Title XVII of the Social Security Act, as amended.

Medically Necessary or Medical Necessity: Health care services ordered by a treating Physician exercising prudent clinical judgment, provided to a Covered Person for the purposes of prevention, evaluation, diagnosis or treatment of that Covered Person's Illness, Injury or pregnancy, that are:

1. consistent with the prevailing professionally recognized standards of medical practice; and, known to be effective in improving health care outcomes for the condition for which it is recommended or prescribed. Effectiveness will be determined by validation based upon scientific evidence, professional standards and consideration of expert opinion, and
2. clinically appropriate in terms of type, frequency, extent, site and duration for the prevention, diagnosis or treatment of the Covered Person's Illness, Injury or pregnancy. The most appropriate setting and the most appropriate level of service is that setting and that level of service, that is the most cost effective considering the potential benefits and harms to the patient. When this test is applied to the care of an inpatient, the Covered Person's medical symptoms and conditions must require that treatment cannot be safely provided in a less intensive medical setting; and
3. not more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the prevention, diagnosis or treatment of the patient's Illness, Injury or pregnancy, without adversely affecting the Covered Person's medical condition; and
4. not provided primarily for the convenience of the following:
   a. the Covered Person;
   b. the Physician;
   c. the Covered Person's family;
   d. any other person or health care provider; and
5. not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses or treatment procedures.

BCBSNE will determine whether services are Medically Necessary. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a treating Physician.

Membership Unit: The category of persons to be provided benefits pursuant to the Subscriber's enrollment.

1. Single Membership: This option provides benefits for Covered Services provided to the Subscriber only.
2. Subscriber-Spouse Membership: This option provides benefits for Covered Services provided to the Subscriber and his or her spouse.
3. Single Parent Membership: This option provides benefits for Covered Services provided to the Subscriber and his or her Eligible Dependent children, but not to a spouse.
4. Family Membership: This option provides benefits for Covered Services provided to the Subscriber and his or her Eligible Dependents.

Other Membership Units may be available as determined by BCBSNE and the Group.

Noncovered Services: Services that are not payable under the Plan.

Occlusion: Any contact between biting or chewing surfaces of maxillary (upper) and mandibular (lower) teeth.

On-site Plan: A Blue Cross and/or a Blue Shield Plan in another Blue Cross and Blue Shield Association Service Area, which administers Claims through the BlueCard Program for Nebraska Covered Persons residing or traveling in that Service Area.

Orthognathic Surgery: Surgery performed to correct facial imbalances caused by abnormalities of the jaw bones.

Osteotomy: Surgical cutting of bone.

Out-of-network Allowance: An amount BCBSNE uses to calculate payment for Covered Services to an Out-of-network Provider. This amount will be based on the Contracted Amount for Nebraska Providers or an amount determined by the On-site Plan for out-of-area Providers.

Palliative: Action that relieves pain but is not curative.

Periodontal: Pertaining to the supporting and surrounding tissues of the teeth.

Physician: Any person holding an unrestricted license who is duly authorized to practice medicine and surgery, and to prescribe drugs.

Plan Administrator: The administrator of the Plan as defined by ERISA.

Preferred Provider: A health care provider (Hospital, Dentist, Physician or other health care provider) who has contracted to provide Services as part of the network in Nebraska, or if in another state, who is a Preferred Provider with the BlueCard Program PPO network.

Preferred Provider Organization: Panel of Dentists, Physicians and other health care providers who belong to a network of Preferred Providers, which agrees to more effectively manage health care costs.

Pulpotomy: Surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing; pulp amputation.

Qualified Beneficiary: Under COBRA, an individual who must in certain circumstances, be offered the opportunity to elect COBRA coverage under a group health plan. The term generally includes a covered employee's spouse or dependent children who were covered under the group health plan on the day before a Qualifying Event, as well as a covered employee who was covered under the group health plan on the day before a Qualifying Event that is a termination of employment or a reduction in hours. The term also includes a child born to or adopted by a covered employee during a period of COBRA coverage.

Qualifying Event: The circumstances that entitle persons to elect COBRA coverage.

Root Canal: The portion of the pulp cavity inside the root of a tooth; the chamber within the root of the tooth that contains the pulp.

Schedule of Benefits: A summarized personal document which provides information about Deductibles, Coinsurance, special benefits, maximums and limitations of coverage. It also indicates the type of Membership Unit selected and whether or not waiting periods are in effect. This term also includes the Schedule of Benefits Summary.

Schedule of Benefits Summary: See definition of Schedule of Benefits.

Scientifically Validated: A technology, a drug, biological product, device, diagnostic, treatment or procedure is Scientifically Validated if it meets all of the factors set forth below:

1. Technologies, drugs, biological products, devices and diagnostics must have final approval from the appropriate government regulatory bodies. A drug or biological product must have final approval from the Food and Drug Administration (FDA). A device must have final approval from FDA for those specific indications and methods of use that is being evaluated. FDA or other governmental approval is only one of the factors necessary to determine Scientific Validity.
2. The Scientific Evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

   The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, Injury, Illness or condition. In addition there should be evidence based on established medical facts that such measurement or alteration affects the health outcomes.

   Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Our evidence includes, but is not limited to: Blue Cross and Blue Shield Association Technology Evaluation Center technology evaluations; Hayes Directory of New Medical Technologies' Status; Centers for Medicare and Medicaid Services (CMS) Technology Assessments and United States Food and Drug Administration (FDA) approvals.
3. The technology must improve the net health outcome.
4. The technology must improve the net health outcome as much as or more than established alternatives.
5. The improvement must be attainable outside the investigational settings.

BCBSNE will determine whether a technology is Scientifically Validated.

Space Maintainer: A passive appliance, usually cemented in place, that holds teeth in position until the permanent teeth erupt.

Subscriber: An individual who enrolls for dental coverage and is named on an identification card, and who is:

1. an employee hired by an employer who makes application for dental coverage for its employees;
2. a retiree qualified to receive benefits as defined by the Plan; or
3. a COBRA Qualified Beneficiary.

Temporomandibular Joint (TMJ): The connecting joint between the base of the skull (temporal bone) and the lower jaw (mandible).

PLAN INFORMATION

Plan Name:	Contractors, Laborers, Teamsters and Engineers Health and Welfare Plan
Employer:	A list of participating employers is available from the Plan Administrator
Employer Identification Number:	47-0469477
Plan Identification Number:	501
Type of Plan:	Dental
Funding:	Self-Insured
Plan Year:	January 1 - December 31
Plan Administrator:	Board of Trustees 10334 Ellison Circle Omaha, Nebraska 68134 (402) 491-3751
Type of Administration:	Insurer Contract Administration (Administrative Services Agreement)
Participating Employers:	Multi-Employer Trust
Registered Agent for Service of Legal Process:	CLT&E 10334 Ellison Circle Omaha, Nebraska 68134 (402) 491-3751 Service of legal process may also be made upon the Plan Administrator
Contributions:	Employer and Employees
Contract Administration* of this Plan is with:	Blue Cross and Blue Shield of Nebraska 1919 Aksarben Drive • P.O. Box 3248 Omaha, Nebraska 68180-0001 (402) 390-1800
Amendment or Termination:	CLT&E, as Plan Sponsor, has the right to amend or terminate the plan at any time

* Blue Cross and Blue Shield of Nebraska provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. Blue Cross and Blue Shield of Nebraska liability may occur only under a stop loss provision set forth in a stop loss agreement with the Group.

CHANGE OF ELIGIBILITY RULES/BENEFITS

The Trustees, at their discretion, are empowered to change or amend the foregoing Eligibility Rules or benefits at any time.

CONTRIBUTIONS BY SELF-EMPLOYED

No contributions will be accepted or benefits afforded to individuals who are self-employed, except participating owner-operators and such contributions shall not be less than 175 hours per month (such owner-operators are required to sign a corresponding Participation Agreement).

NON-BARGAINING UNIT PARTICIPATION

Not withstanding any other Provision of the Plan, if the employer elects, in writing on a form provided by the Plan, then all non-bargaining employees must participate in the CLT&E Health & Welfare Plan subject to the following terms and conditions:

(a) The effective date of this amendment shall be April 1, 1997. Any current employer must elect coverage under this amendment by October 1, 1997. Any new employer must elect coverage under this amendment on the date of signing a Collective Bargaining Agreement with a participating Union. During the month of April in the years following 1997, each employer with a current Collective Bargaining Agreement can elect coverage under this amendment.

(b) Except for those Participation Agreements executed on or before October 1, 1997, the term of the Participation Agreement shall be for a period of one year, commencing on April 1 (hereinafter "coverage date") and ending on March 31 annually. Each Participation Agreement shall be deemed renewed automatically for an additional year (12 months) beginning on April 1 (coverage date) unless the employer elects in writing to stop participation and such writing is delivered to and receipted by the Trust sixty (60) days or more before the coverage date (April 1). Those Participation Agreements executed on or before October 1, 1997 shall be effective on the date of signing and shall continue in effect through and until March 31, 1998 and annually thereafter as set forth above.

(c) All of the employer's Non-Bargaining Unit employees, including owners, must participate provided that the Non-Bargaining Unit employees, excluding the owner, are not considered members of a recognized construction trade or craft.

(d) Only employees regularly employed for more than thirty (30) hours a week shall be allowed to participate. They shall participate from the date of hire and the employer premium payment shall commence from the date of hire and continue until the employee ceases employment in the Non-Bargaining Unit capacity.

(e) The employer must pay the entire premium per month for each participating employee, with or without Eligible Dependents, and the sum paid per month shall be the current COBRA rate chargeable by the fund. The monthly cost is subject to change by action of the Board of Trustees. All premiums must be paid in advance.

(f) All employers must agree to contribute for all eligible Non-Bargaining Unit employees for a minimum period of twelve (12) consecutive full calendar months from the date the employer elects, in writing, to become a signatory to the Plan for his Non-Bargaining Unit employees and thereafter in twelve (12) consecutive month periods if the employer does not elect in writing out of participation in the CLT&E Health and Welfare Plan.

(g) The right to contribute for Non-Bargaining Unit employees shall cease if the employer has no Collective Bargaining Agreement with any Participating Union in the CLT&E Health and Welfare Plan.

NON-BARGAINING UNIT PARTICIPATION (CONTINUED)

Coverage shall cease immediately if employer has no current Collective Bargaining Agreement with any Participating Union in the CLT&E Health and Welfare Plan. **PROVIDED HOWEVER,** the right and obligation to continue to make contributions and to obtain coverage for Non-Bargaining Unit employees shall continue so long as there is a legally enforceable obligation to pay for any Bargaining Unit employee whose Bargaining Representative is any other Participating Union.

(h) The coverage of Non-Bargaining Unit employees shall cease when they are no longer employed by a contributing employer in a job which makes them eligible for participation in the CLT&E Health and Welfare Plan. COBRA rights shall be provided as required by law.

(i) The employer can contribute to the CLT&E Health and Welfare Plan but may not contribute to the CLT&E Pension Plan for the Non-Bargaining Unit employees.

(j) Any Non-Bargaining Unit employee who is currently shown to be eligible under the terms of the Plan shall continue to be eligible from the effective date, provided the employer has elected to have the Non-Bargaining Unit employees participate and provided the participant satisfies the Plan eligibility rules in the future.

(k) The employer must, by written designation on forms furnished by the Fund Office, disclose all employees and their Eligible Dependents who may be eligible under the above rules, provided their current job description, their hours worked per week, and allow an audit by the Fund to verify eligibility. The information must be provided monthly with premium remittance.

(l) On the termination of employment of any Eligible Participant, the employer must inform the Plan, in writing, no later than seven (7) working days following termination.

(m) The covered owners' employers must provide a CERTIFICATE OF INSURANCE evidencing that he or she is covered by workers compensation insurance.

(n) To be eligible for this coverage, the employer must include all employees from all organizations which are considered related under the Internal Revenue Code 414.

(o) When an employer makes an election for Non-Bargaining Unit coverage, the premium of two (2) months is due in advance immediately at the time of election to participate. Thereafter, the contributions are due in advance with their monthly contribution reports on the first of each month thereafter.

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