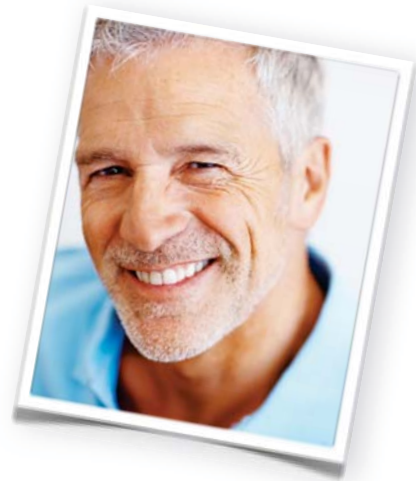




**SANTA ROSA
JUNIOR COLLEGE**

Santa Rosa Junior College
Dental Plan

Your Dental Plan



The Santa Rosa Junior College dental plan is a self-funded plan designed to minimize administrative costs and maximize the benefits to our covered employees and their dependents

A dental plan is more than just about having a nice smile. Research indicates that regular preventive dental visits can yield health benefits beyond improved teeth and gums. The Santa Rosa Junior College provides the dental plan to its employees to help them be healthy, and we recommend regular cleanings and preventive visits (the plan pays for three such cleanings and preventive visits per year).

The College's dental plan pays an increasing percentage of dental claims depending on how long the employee has been employed (and presuming the member used the plan at least once in the benefit year). The plan includes a special network of Northern California dentists, but any dentist may be seen.

This booklet constitutes the plan's Summary Plan Description. If you have any questions on the plan, please contact the plan's administrator:

Arrow Benefits Group

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P.O. Box 750578

Petaluma, CA 94975

707-544-1801

800-479-8479

YOUR GROUP DENTAL INSURANCE PLAN

Santa Rosa Junior College

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IMPORTANT NOTICE

SECTION I The Dental benefits are directly funded through and provided by Arrow Benefits Group, and are not insured by Arrow Benefits Group. Arrow Benefits Group has the sole responsibility and liability for payment of Dental benefits.

The dental plan uses the Shirrell Dental Network, but services may be obtained from any licensed provider.

DENTAL HIGHLIGHTS

This page provides a quick guide to some of the Dental Expense Insurance *plan* features which people most often want to know about. But it's not a complete description of your Dental Expense Insurance *plan*. Read the following pages carefully for a complete explanation of what the *plan* pays, limits and excludes.

Benefit Year Cash Deductible

For Preventive and Diagnostic Services	None
For Basic and Major Services for each covered person for each covered person	None

This plan is an incentive plan. If an employee or covered family member has utilized the program during the benefit year (October 1 - September 30), the percentage of payment will increase each year until Preventive and Diagnostic services reach 100% coinsurance, at which point the covered member will be at the maximum percentage. If the covered member did not see a dental provider in the benefit year, the coinsurance percentage below would remain frozen. Once the covered member saw a dental provider again, the coinsurance amount for Preventive and Diagnostic services would increase (if not already at 100%) at the start of the next benefit year. However, if the member lost eligibility under the plan and then later returned, the covered member would start over at 80%.

First Benefit Year of Coverage:

Payment Rates:

For Preventive and Diagnostic (P&D) Services	80%
For Basic and Major Services	60%

Second Benefit Year of Coverage:

Payment Rates:

For Preventive and Diagnostic (P&D) Services	90%
For Basic and Major Services	70%

Third Benefit Year of Coverage:

Payment Rates:

For Preventive and Diagnostic (P&D) Services	100%
For Basic and Major Services	90%

Benefit Year Payment Limit (Regardless of Year of Coverage):

For P&D, Basic and Major Services	Up to \$1,700
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Dental Accident Benefit (Regardless of Year of Coverage):

Paid at 100% separate from other plan benefits:	Up to \$1,500
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The claim must be submitted within 180 days of the accident. Limitations apply.



An Important Notice About Continuation Rights

This plan complies with applicable federal continuation laws under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and the Family and Medical Leave Act of 1993, as amended.

ELIGIBILITY FOR DENTAL COVERAGE

Employee Coverage

Eligible Employees

Employees are eligible if they work on an active basis and belong to an eligible class of employees. To be eligible, employees must work at least 20 hours per week and have met the waiting period mentioned below in "When Your Coverage Begins."

Other Potential Requirements

In the case of contributory coverage, where employees are required to pay all or part of the cost of *employee* coverage, you must agree in writing to such an election before you will be eligible for coverage. This election must be made not more than 31 days after first becoming eligible. If the election is made after that time limit, you will have to wait until the next Open Enrollment period, which occurs every three years. However, you will not have to wait for the next Open Enrollment if you lost other group dental coverage for any of the following reasons: (a) termination of your spouse's employment; (b) loss of eligibility under your spouse's group dental plan; (c) divorce; (d) death of your spouse; or (e) termination of the other group dental plan. This exception only applies if you sign up for coverage under this plan and agree to any employee contributions within 30 days of the loss of the other coverage for any of the reason listed.

When Your Coverage Begins

Coverage begins for active employees on the first of the month following the employee's date of hire. If you are not actively at work on the date that coverage would otherwise start, the coverage will be postponed until the day you return to work.

When Your Coverage Ends

Coverage ends on the last of the month in which your employment ends. However, coverage ends on the date that you die or this plan is cancelled for all employees. If you are required to pay part or all of the cost of the plan and you fail to do so, the coverage will end as of the last day of the period for which you paid the necessary premium.

If coverage ends, you are eligible for continuation coverage under COBRA for a limited period of time if your loss of coverage is due to one of the defined Qualifying Events under COBRA, including reduction in hours or termination of employment.

Dependent Coverage

Eligible Dependents For Dependent Dental Benefits

Eligible dependents are: your legal spouse and domestic partners as defined by Santa Rosa Junior College; your children who are under age 26 and such children of your domestic partner.

Adopted Children And Step-Children

"Unmarried dependent children" includes any child legally adopted by you, including if the child is in your custody under an interim court order of adoption. In addition, any step-children of yours are eligible if they depend upon you for the majority of their support.

Disabled Children

If you have an unmarried child who is older than the normal age limit for dependent coverage and was covered by the plan prior to reaching the plan's normal age limit, he or she may continue to be covered if he or she has a physical or mental disability or a developmental disability and is unable to support himself or herself and relies on you for support. The child may remain covered so long as he or she remains unmarried, disabled, and unable to provide for his or her support and remains supported by you. In order to maintain coverage under this provision, you must provide proof in writing that the child is disabled and dependent upon you for support. You have 31 days after the child reaches the normal limiting age to provide this proof. The plan reserves the right to ask for periodic proof of the child's then current situation.

When Dependent Coverage Starts

You must already be insured for employee coverage or enroll for employee and dependent coverage at the same time, in order to provide coverage for your dependents. Subject to the "Exception" stated below and to the terms of this *plan*, the date your dependent coverage starts depends on when you elect to enroll your *initial dependents* and agree to make any required payments, or you enroll your dependents later as explained below:

Dependents Added at Initial Enrollment

If you do this on or before your *eligibility date*, the dependent's coverage is scheduled to start on the later of the first of the month which coincides with or next follows your *eligibility date* and the date you become insured for employee coverage.

If you do this within the *enrollment period*, the coverage is scheduled to start on the later of the first of the month which coincides with or next follows the date you sign the enrollment form; and the date you become insured for employee coverage.

Dependents Added After the Initial Enrollment

Once you have dependent coverage for your *initial dependents*, you must notify the *plan* when you acquire any new dependents and agree to make any additional payments required for their coverage.

If you do this within 31 days of the date the *newly acquired dependent* becomes eligible, the dependent's coverage will start on the date the dependent first becomes eligible. If you fail to notify the *plan* on time, the *newly acquired dependent*, when enrolled, is a late entrant and is scheduled to start on the date you sign the enrollment form.

Newborn Children the *plan* covers your newborn child for dependent benefits the first of the month following their birth.

When Dependent Coverage Ends

Dependent coverage ends for all of your dependents at the same time that your coverage ends. It also ends when this *plan* ends, or when dependent coverage is dropped from this *plan* for all *employees* or for an *employee's* class.

If you fail to make any required payments for dependent coverage the coverage for your dependents will end. It ends on the last day of the period for which you made any required payments (unless coverage ended earlier for other reasons).

An individual dependent's coverage ends when he or she stops being an *eligible dependent*. Coverage ends the last day of the month that the child attains the coverage age limit. It happens to a spouse when a marriage ends in legal divorce or annulment.

Group Enrollment Period

A group enrollment period is held each third year starting from August 1 to August 31, 2012. During this period, you may elect to enroll in dental insurance under this *plan*. Coverage starts on the October 1st that next follows the date of enrollment.

DENTAL EXPENSE INSURANCE

This insurance will pay many of your and your covered dependents' dental expenses. What the *plan* pays and the terms for payment are explained below.

Covered Charges

Covered charges are reasonable and customary charges for the dental services named in the List of Covered Dental Services.

Arrow Benefits Group maintains a database of average dental costs in its network, and if in-network dental providers are utilized the fees from such providers are deemed approved (for covered expenses). If a non-network dental provider is used, covered fees from such providers are limited to the average fee as determined by Arrow Benefits Group.

This plan only pays for covered services incurred by a *covered person* while that person is insured. A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is prepared. A covered charge for any other *prosthetic device* is incurred on the date the master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. All other covered charges are incurred on the date the services are furnished.

Alternate Treatment

The plan reserves the right to base its benefit payments on the least expensive service within a range of professionally accepted standards of dental practice. In the case of bilateral multiple adjacent missing teeth, the benefit will be based on a removable partial denture.

If more than one type of service can be used to treat a dental condition, the *plan* has the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice. In the case of bilateral multiple adjacent missing teeth, the benefit will be based on a removable partial denture.

Proof of Claim

In order for a claim to be paid, it is required that information acceptable to Arrow Benefits Group be provided. This information can

consist of x-rays, study models, narratives or other diagnostic materials. If the necessary information is not provided, no benefit will be paid.

Pre-Treatment Review

When the expected cost of a proposed course of treatment is expected to be expensive, the *covered person's dentist* may send to Arrow Benefits Group a treatment plan before treatment is started. This must be done on a form acceptable to Arrow Benefits Group. The treatment plan must include: (a) a list of the services to be done, using the American Dental Association Nomenclature and codes; (b) the itemized cost of each service; and (c) the estimated length of treatment. Dental X-rays, study models and whatever else the *plan* needs to evaluate the treatment plan must be sent to us, too.

Once the treatment plan is received, Arrow Benefits Group will review it and estimate what the *plan* will pay. The estimate will be sent to the *covered person's dentist*. If Arrow Benefits Group does not agree with a treatment plan, or if one is not sent in, it reserves the right to base plan payments on treatment suited to the *covered person's* condition by accepted standards of dental practice. This does not guarantee a specific payment by the plan unless the work is performed as stated in the plan and the *person* remained insured. Such treatment remains subject to all of the other limitations of the plan.

Benefits From Other Sources

If you are covered by this *plan* and a similar plan, such as through your spouse's employer, the plan will coordinate its benefits with the benefits from the other plan. For more information on this, see the section on COORDINATION OF BENEFITS.

The Benefit Provisions

Preventive & Diagnostic, Basic, and Major Services

There is no deductible for Preventive & Diagnostic, Basic or Major services. The plan pays for such services at the applicable payment rate. In addition, the *plan* provides a benefit for accidents at 100% of allowed charges up to a benefit year maximum of \$1,500 that is separate from the rest of the plan. The claim must be submitted within 180 days of the accident for the separate accident benefit to apply, and the covered member must submit documentation of the accident. Limitations apply.

All charges must be incurred while the *covered person* is insured. The plan has an annual maximum payment each *benefit year* of \$1,700.00 (excluding the separate benefit for covered accidents).

Orthodontic Services

No coverage is provided for orthodontic services.

After This Insurance Ends

The plan will not pay for charges incurred after this insurance ends. But the plan will pay for the following if all work is finished in the 31 days after this insurance ends: (a) a crown, bridge or cast restoration, if the tooth is prepared before the insurance ends; (b) any other *prosthetic device*, if the master impression is made before the insurance ends; and (c) root canal treatment, if the pulp chamber is opened before the insurance ends.

Special Limitations

Teeth Lost Or Missing Before A Covered Person Becomes Insured By This Plan

A *covered person* may have one or more congenitally missing teeth. The plan will not pay for a *prosthetic device* which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the *covered person* became insured by this *plan*. This limitation only applies to congenitally missing teeth, not to a tooth that had been pulled.

Exclusions

The plan will not pay for:

- Oral hygiene, plaque control or diet instruction.
- Desensitizing medicaments.
- Prescription medication.
- Treatment which does not meet accepted standards of dental practice.
- Treatment which is experimental in nature.
- Extraoral superior or inferior maxillary film.

The plan will not pay for any *appliance* or *prosthetic device* used to:

- Change vertical dimension.
- Restore or maintain occlusion.
- Splint or stabilize teeth for periodontic reasons.
- Replace tooth structure lost as a result of abrasion or attrition.

The plan will not pay for any service furnished for cosmetic reasons. This includes, but is not limited to:

- Characterizing and personalizing *prosthetic devices*.
- Services with respect to congenital (hereditary) or development (following birth) malformations, surgery or dentistry for purely cosmetic reasons, including but not limited to; cleft, palate, maxillary and mandibular (upper and lower jaw) malformations, enameled hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
- Making facings on *prosthetic devices* for any teeth in back of the second bicuspid.

The plan will not pay for replacing an *appliance* or *prosthetic device* or processed veneer with a like appliance or device, unless:

- It is at least four years old and can't be made usable.
- It is damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can't be made serviceable.

The plan will not pay for any service, appliance, device or modality intended to treat disturbances of the temporo-mandibular joint.

The plan will not pay for:

- Replacing a lost, stolen or missing *appliance* or *prosthetic device*.

- Making a spare *appliance* or device.

- Tooth transplants,

- Surgical repositioning of the jaw.

- The plan will not pay for treatment needed due to:

- An on-the-job or job-related injury.

- Overdentures

- A condition for which benefits are payable by Workers' Compensation or similar laws.

The plan will not pay for treatment for which no charge is made. This usually means treatment furnished by:

- The *covered person's* employer, labor union or similar group, in its dental or medical department or clinic.

- A facility owned or run by any governmental body.

- Any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made and the *plan* is legally required to pay it, we will.

- Experimental procedures.

- All hospital costs and any additional fees charged by the dentist for hospital treatment.

- Extra-oral grafts (grafting of tissues from outside of the Temporomandibular Jaw (jaw joints)).

- Orthodontic services (treatment of malalignment of teeth and/or jaws) including orthodontic surveys.

- If an eligible person selects a more expensive plan of treatment than is customarily provided, or specialized techniques rather than standard procedure, the plan will pay the applicable percentage of the lesser fee and the patient is responsible for the remainder of the dentist's fee. For example, a gold crown where a filling would restore the tooth, or a precision denture where a standard denture would suffice.

- Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing services due to malocclusion, or for stabilizing the teeth. Such services include, but are not limited to, equilibration and periodontal splinting.

- Cone Beam images and Extraoral films.

- Occlusal adjustments.

List of Covered Dental Services

The services covered by this *plan* are named in this list. Each service on this list has been placed in one of three sections, which are explained below. A separate payment rate applies to each section. All covered dental services must be furnished by or under the direct supervision of a *dentist*. And they must be usual and necessary treatment for a dental condition.

Preventive & Diagnostic Dental Services

Prophylaxis, including periodontal prophylaxis (Topical application of fluoride is limited to *covered persons* under age 15 and limited to three treatments in any one benefit year) - Allowance includes examination, scaling and polishing.

Office Visits And Examinations

Initial or periodic oral examination (limited to three (3) examinations and prophylaxis treatments in one benefit year).

- Emergency palliative treatment and other non-routine, unscheduled visits.

Space Maintainers (Limited to covered persons under age 16 and limited to initial appliance only) Allowance includes all adjustments in the first six months after installation:

- Fixed, unilateral, band or stainless steel crown type.

- Fixed, unilateral, cast type.

- Removal, bilateral type.

Diagnostic Services Allowance includes examination and diagnosis.

- X-Rays

- Full mouth series of at least 14 films including bitewings, if needed (limited to once in any 36 consecutive month period).

- Bitewing films (limited to a maximum of four films in one visit, in any six consecutive month period).

- Other intraoral periapical or occlusal films - single films (limited to 4 periapical & 2 occlusal in any 12 consecutive month period).
- Panoramic film, maxilla and mandible.

Dental Sealants Posterior Teeth

- Topical application of sealant (limited to the unrestored permanent molar teeth of *covered persons* under age 15 and limited to one treatment per tooth in any 36 consecutive month period).

Basic Dental Services

Office Visits And Examinations

Diagnostic consultation with a dentist other than the one providing treatment - The *plan* pays for this only if no other service is rendered during the visit.

Diagnostic Services Allowance includes examinations and diagnosis.

- Diagnostic casts - complex restorative cases only.
- Biopsy and examination of oral tissue.

Restorative Services Multiple restorations on one surface will be considered one restoration. Also see “Restorative Services” below.

- Amalgam restorations.
- Synthetic restorations: Silicate cement, Acrylic or plastic, and Composite resin.
- Crowns: Stainless steel.
- Pins: Pin retention, exclusive of restorative material.

Note: composite restorations of posterior teeth are a covered benefit.

Endodontic Services

Allowance includes routine X-Rays and cultures, but excludes final restoration.

- Pulp capping, direct.
- Remineralization (Calcium Hydroxide), as a separate procedure.
- Vital pulpotomy.
- Apexification.
- Root canal therapy on non-vital (nerve-dead) teeth: Traditional therapy, and Medicated paste therapy, N2 Sargenti.
- Apicoectomy, as a separate procedure or in conjunction with other endodontic procedures.

Periodontic Services

Allowance includes the treatment plan, local anesthetics and post-surgical care.

- Gingivectomy or gingivoplasty, per quadrant (limited to once in 36 months on a given area.)
- Gingivectomy, per tooth (fewer than 4 teeth).
- Sub-gingival curettage and root planing, per quadrant (limited to a maximum of 4 quadrants in any 12 consecutive month period).
- Pedicle or free soft tissue grafts, including donor sites.
- Osseous surgery, including flap entry and closure, per quadrant (once every 3 years).
- Osseous grafts, including flap entry, closure and donor sites.
- Muco-gingival surgery.

Oral Surgery Allowance includes routine X-Rays, the treatment plan, local anesthetics and post-surgical care.

- Extractions
- Uncomplicated non-surgical extraction, one or more teeth.
- Surgical removal of erupted teeth, involving tissue flap and bone removal.
- Surgical removal of impacted teeth.

Other Surgical Procedures

- Alveolectomy, per quadrant.
- Stomatoplasty with ridge extension, per arch.
- Removal of mandibular tori, per quadrant.
- Excision of hyperplastic tissue.
- Excision of pericoronal gingiva, per tooth.
- Removal of palatal torus.
- Removal of cyst or tumor.
- Incision and drainage of abscess.
- Closure of oral fistula or maxillary sinus.
- Reimplantation of tooth.
- Frenectomy.
- Suture of soft tissue injury.
- Sialolithotomy for removal of salivary calculus.
- Closure of salivary fistula.
- Dilation of salivary duct.

- Sequestrectomy for osteomyelitis or bone abscess, superficial.
- Maxillary sinusotomy for removal of tooth fragment or foreign body.

Prosthodontic Services

Specialized techniques and characterization are not covered. Also see "Prosthodontic Services" below.

- Adding teeth to partial dentures to replace extracted natural teeth.
- Repairs to crowns - allowance based on the extent and nature of damage and the type of material involved.

Other Services - General anesthesia in connection with surgical procedures only.

- Injectable antibiotics needed solely for treatment of a dental condition.

Major Dental Services

Restorative Services Cast restorations and crowns are covered only when needed because of decay or injury, and only when the tooth cannot be restored with a routine filling material. Also see "Basic Restorative Services."

- Inlays
- Onlays, in addition to inlay allowance.
- Crowns and Posts
- Acrylic with metal.
- Porcelain.
- Porcelain with metal.
- Full cast metal (other than stainless steel).
- 3/4 cast metal (other than stainless steel).
- Cast post and core, in addition to crown (not a thimble coping).
- Steel post and composite or amalgam core, in addition to crown.
- Cast dowel pin (one-piece cast with crown) - Allowance based on type of crown.
- Acrylic or plastic, without metal
- Crown buildup.
- Labial veneers.
- Recementation
- Inlay or onlay.
- Crown.
- Bridge.

Prosthodontic Services

Specialized technique and characterizations are not covered.

- Fixed bridges - Each abutment and each pontic makes up a unit in a bridge.
- Bridge abutments - See inlays and crowns under "Restorative Services."
- Bridge Pontics
- Cast metal, sanitary.
- Plastic or porcelain with metal.
- Slotted facing.
- Slotted pontic.
- Simple stress breakers, per unit.
- Removable bridges, unilateral partial, one piece chrome casting, clasp attachment, including pontics.
- Dentures - Allowance includes all adjustments done by the dentist furnishing the denture in the first 6 months after installation.
- Full dentures, upper or lower.
- Partial dentures - Allowance includes base, all clasps, rests and teeth.
- Upper, with two chrome clasps with rests, acrylic base.
- Upper, with chrome palatal bar and clasps, acrylic base.
- Lower, with two chrome clasps with rests, acrylic base.
- Lower, with chrome lingual bar and clasps, acrylic base.
- Stayplate base, upper or lower (anterior teeth only).
- Denture repairs, acrylic
- Repairing dentures, no teeth damaged.
- Repairing dentures and replace one or more broken teeth.
- Replacing one or more broken teeth, no other damage.
- Denture repairs, metal - Allowance based on the extent and nature of damage and on the type of materials involved.
- Denture duplication, jump case (limited to once per denture in any 48 consecutive month period).
- Denture reline (limited to once per denture in any 24 consecutive month period):
- Office reline.
- Laboratory reline.
- Denture adjustments (limited to adjustments made by a dentist other than the one providing the denture, and adjustments are more

than 6 months after the initial installation).

- Tissue conditioning (limited to a maximum of 2 treatments per arch in any 24 consecutive month period).
- Repairs to bridges - allowance based on the extent and nature of damage and the type of materials involved).
- Implants

Prosthetic appliances (including, but not limited to, fixed bridges and partial or complete dentures) will be replaced only after four years have elapsed following any prior provision of such appliances under the *plan*.

The plan will pay the applicable percentage of the dentist's fee for a standard cast chrome, acrylic partial denture or a standard complete denture, up to a maximum fee allowance which is at least the Prevailing Fee for a standard denture. (A "standard" complete or partial denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth and which is constructed using accepted and conventional procedures and materials.) The maximum allowance is revised periodically as dental fees change. Any denture and/or related service for which a charge is made which exceeds this allowance is considered an optional service, and the patient is responsible for the portion of the dentist's fee in excess of the *plan's* allowable amount.

COORDINATION OF BENEFITS

Important Notice This provision applies to all dental expense benefits under this plan. It does not apply to death, dismemberment, or loss of income benefits.

Purpose Of This Provision

An employee may be covered for dental expense benefits by more than one plan. For instance the covered person may be covered by this plan as an employee and by another plan as a dependent of his or her spouse. If he or she is, this provision allows us to coordinate what we pay with what another plan pays. We do this so the covered person doesn't collect more in benefits than he or she incurs in charges.

Definitions

"The *plan*" means this self-funded dental plan, as administered by Arrow Benefits Group.

"Plan" means any of the following that provides health expense benefits or services:

(A) group, blanket, or franchise insurance plans;

(B) group Blue Cross plans, group Blue Shield plans, or other service or prepayment plans on a group basis;

(C) union welfare plans, employer plans, employee benefits plans, trustee labor and management plans, or other plans for members of a group;

(D) programs or coverages required or provided by law, including Medicare or other similar governmental benefits.

"Plan" does not include Medicaid or any other government program or coverage which the plan is not allowed to coordinate with by law or the medical payment benefits included in traditional "fault-type" automobile contracts. Nor does it include any plan which this *plan* supplements.

"This plan" means the part of the group plan subject to this provision.

"Member" means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a member.

"Allowable expense" means any needed, reasonable, and usual expense for health care incurred by a member or dependent under this plan and at least one other plan. When a plan provides service instead of cash payment, the *plan* views the reasonable cash value of each service as an allowable expense and as a benefit paid. The *plan* also views benefits payable by another plan as an allowable expense and as a benefit paid, whether or not a claim is filed under that plan.

"Claim determination period" means a calendar year in which a member or dependent is covered by this plan and at least one other plan and incurs one or more allowable expense under such plans.

How This Provision Works

The *plan* applies this provision when a member or dependent is covered by more than one plan. When this happens the *plan* considers each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

(A) A plan that covers a person as a member pays first; the plan that covers a person as a dependent pays second; except that, if the person is also a Medicare beneficiary, Medicare is secondary to the plan covering the person as a dependent.

(B) A plan that covers a person as an active employee or as a dependent of such employee pays first. A plan that covers a person as a laid-off or retired employee or as a dependent of such employee pays second.

But, if the plan that the *plan* is coordinating with does not have a similar provision for such persons, then (B) will not apply.

(C) A plan that covers a person as an active employee or as a dependent of such employee pays first. A plan that covers a person or that person's dependent under a right of continuation pursuant to federal or state law pays second. But, if the plan that the *plan* is coordinating with doesn't have a similar provision for such persons, then (C) will not apply.

(D) Except for dependent children of separated or divorced parents, the following governs which plan pays first when the person is

a dependent of a member:

A plan that covers a dependent of a member whose birthday falls earliest in the calendar year pays first. The plan that covers a dependent of a member whose birthday falls later in the calendar year pays second. The member's year of birth is ignored.

But, if the plan that the *plan* is coordinating with does not have a similar provision for such persons, then (D) will not apply and the other plan's coordination provision will determine the order of benefits.

(E) For a dependent child of separated or divorced parents, the following governs which plan pays first when the person is a dependent of a member:

(1) When a court order makes one parent financially responsible for the health care expenses of the dependent child, then that parent's plan pays first.

(2) If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody;

(3) The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules (A), (B), (C), (D) and (E) don't determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when the *plan* applies this provision, it pays less than it would otherwise pay, it will apply only that reduced amount against payment limits of this *plan*.

The Plan's Right To Certain Information

In order to coordinate benefits, the *plan* needs certain information. An employee must supply the *plan* with as much of that information from any source. And if another insurer needs information to apply its coordination provision, the *plan* has the right to give that insurer such information. If the *plan* gives or gets information under this section it can't be held liable for such action. When payments that should have been made by this *plan* have been made by another plan, the *plan* have the right to repay that plan. If it does so, it is no longer liable for that amount. And if it pays out more than it should have, it has the right to recover the excess payment.

Small Claims Waiver The *plan* doesn't coordinate payments on claims of less than \$50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above \$50.00, it will count the entire amount of the claim when it coordinates payment.

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

Active Appliance means an appliance, like braces or a functional orthotic used for orthodontic treatment to move teeth or reposition the jaw.

Appliance means any dental device other than a *prosthetic device*.

Benefit Year with respect to this *plan's* dental expense insurance, means a 12 month period which starts on October 1st and ends on September 30th of each year.

Close Relative means: (a) a *covered person's* spouse, children, parents, brothers and sisters; and (b) any other person who is part of a *covered person's* household. The *plan* does not pay for services and supplies furnished by *close relatives*.

Covered Person with respect to this *plan's* dental expense insurance, means an *employee* or any of his or her *covered dependents*.

Dentist means any dental or medical practitioner the *plan* is required by law to recognize who: (a) is properly licensed or certified under the laws of the state where he practices; and (b) provides services which are within the scope of his license or certificate and covered by this *plan*.

Eligibility Date for dependent coverage is the earliest date on which: (a) you have initial dependents; and (b) are eligible for dependent coverage.

Eligible Dependent is defined in the provision entitled "Dependent Coverage."

Employee means a person who works for the *employer* at the *employer's* place of business, and whose income is reported for tax purposes using a W-2 form.

Employer means Santa Rosa Junior College.

Enrollment Period with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.

Full-time means the *employee* regularly works at least the number of hours in the normal work week set by the *employer* (but not

less than 20 hours per week), at his *employer's* place of business.

Initial Dependents means those *eligible dependents* you have at the time you first become eligible for *employee* coverage. If at this time you do not have any *eligible dependents*, but you later acquire them, the first *eligible dependents* you acquire are your *initial dependents*.

Injury with respect to this *plan's* dental expense insurance, means all damage to a *covered person's* mouth due to an accident, and all complications rising from that damage. But the term *injury* does not include damage to teeth, *appliances* or *prosthetic devices* which results from chewing or biting food or other substances.

Newly Acquired Dependent means an *eligible dependent* you acquire after you already have coverage in force for *initial dependents*.

Orthodontic Treatment means the movement of one or more teeth by the use of *active appliances*. It includes: (a) diagnostic services; (b) the treatment plan; (c) the fitting, making and placement of an *active appliance*; and (d) all related office visits, including post-treatment stabilization.

Plan means group *plan* administered by Arrow Benefits Group.

Prosthetic Device means a restorative service which is used to replace missing or lost teeth or tooth structure. It includes all types of dentures, crowns, bridges, veneers, pontics and cast restorations.

Qualified Medical Child Support Order

Federal law requires that group health plans (including dental plans) provide medical care coverage of a dependent child pursuant to a qualified medical child support order (QMCSO). A "qualified medical child support order" is a judgment or decree issued by a state court that requires a group medical plan to provide coverage to the named dependent child(ren) of an employee pursuant to a state domestic relations order. For the order to be qualified it must include:

- The name of the group health plan to which it applies.
- The name and last known address of the employee and the child(ren).
- A reasonable description of the type of coverage or benefits to be provided by the plan to the child(ren).
- The time period to which the order applies.
- A dependent enrolled due to a QMCSO will not be considered a late enrollee in the plan.

Note: A QMCSO cannot require a group health plan to provide any type or form of benefit or option not otherwise available under the plan except to the extent necessary to meet medical child support laws described in Section 90 of the Social Security Act. If you have questions about this statement, see the plan administrator.

Arrow Benefits Group's Responsibilities

The dental expense benefits provided by this plan are funded solely by the employer. The benefits **are not** guaranteed by a policy of insurance. Arrow Benefits Group supplies administrative services, such as claims services, including the payment of claims, preparation of employee benefit booklets, and changes to such benefit booklets.

Group Health Benefits Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Plan Administrator. Arrow Benefits Group is the Claims Administrator with respect to processing claims. Arrow Benefits Group has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim. The Plan Administrator has discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

Definitions "Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit. A failure to cover an item or service: (a) due to the application of any utilization review; or (b) because the item or service is determined to be experimental or investigational, or not medically necessary or appropriate, is also considered an adverse determination.

"Group Health Benefits" means any dental, out-of-network point-of-service medical, major medical, vision care or prescription drug coverages which are a part of this plan.

"Pre-service claim" means a claim for a medical care benefit with respect to which the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of receipt of care.

"Post-service claim" means a claim for payment for medical care that already has been provided.

"Urgent care claim" means a claim for medical care or treatment where making a non-urgent care decision: (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, as determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care.

Note: Any claim that a physician with knowledge of the claimant's medical condition determines is a claim involving urgent care will be treated as an urgent care claim for purposes of this section.

Timing For Initial Benefit Determination

The benefit determination period begins when a claim is received. Arrow Benefits Group will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.

Urgent Care Claims. Arrow Benefits Group will make a benefit determination within 72 hours after receipt of an urgent care claim. If a claimant fails to provide all information needed to make a benefit determination, Arrow Benefits Group will notify the claimant of the specific information that is needed as soon as possible but no later than 24 hours after receipt of the claim. The claimant will be given not less than 48 hours to provide the specified information.

Arrow Benefits Group will notify the claimant of the benefit determination as soon as possible but not later than the earlier of: the date the requested information is received; or the end of the period given to the claimant to provide the specified additional information.

The required notice may be provided to the claimant orally within the required time frame provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

Pre-Service Claims. Arrow Benefits Group will provide a benefit determination not later than 15 days after receipt of a pre-service claim. If a claimant fails to provide all information needed to make a benefit determination, Arrow Benefits Group will notify the claimant of the specific information that is needed as soon as possible but no later than 5 days after receipt of the claim. A notification of a failure to follow proper procedures for pre-service claims may be oral, unless a written notification is requested by the claimant. The time period for providing a benefit determination may be extended by up to 15 days if Arrow Benefits Group determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 15-day period.

If Arrow Benefits Group extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Post-Service Claims. Arrow Benefits Group will provide a benefit determination not later than 30 days after receipt of a post-service claim. If a claimant fails to provide all information needed to make a benefit determination, Arrow Benefits Group will notify the claimant of the specific information that is needed as soon as possible but no later than 30 days after receipt of the claim. The time period for completing a benefit determination may be extended by up to 15 days if Arrow Benefits Group determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 30-day period.

If Arrow Benefits Group extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Concurrent Care Decisions. A reduction or termination of an approved ongoing course of treatment (other than by plan amendment or termination) will be regarded as an adverse benefit determination. This is true whether the treatment is to be provided (a) over a period of time; (b) for a certain number of treatments; or (c) without a finite end date. Arrow Benefits Group will notify a claimant at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal.

In the case of a request by a claimant to extend an ongoing course of treatment involving urgent care, Arrow Benefits Group will make a benefit determination as soon as possible but no later than 24 hours after receipt of the claim.

Adverse Benefit Determination

If a claim is denied, Arrow Benefits Group will provide a notice that will set forth:

the specific reason(s) for the adverse determination; reference to the specific plan provision(s) on which the determination is based; a description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;

a description of the plan's claim review procedures and the time limits applicable to such procedures, including a statement indicating that the claimant has the right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination;

identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request; in the case of an adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request; and in the case of an urgent care adverse determination, a description of the expedited review process.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal.

A request for an appeal of an adverse benefit determination involving an urgent care claim may be submitted orally or in writing. Necessary information and communication regarding an urgent care claim may be sent to Arrow Benefits Group by telephone, facsimile or similar expeditious manner.

Arrow Benefits Group will conduct a full and fair review of an appeal which includes providing to claimants the following: the opportunity to submit written comments, documents, records and other information relating to the claim; the opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Arrow Benefits Group will:

- provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;
- in deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Arrow Benefits Group will notify the claimant of its decision regarding review of an appeal as follows:

Urgent Care Claims. Arrow Benefits Group will notify the claimant of its decision as soon as possible but not later than 72 hours after receipt of the request for review of the adverse determination.

Pre-Service Claims. Arrow Benefits Group will notify the claimant of its decision not later than 30 days after receipt of the request for review of the adverse determination.

Post-Service Claims. Arrow Benefits Group will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination.

Alternative Dispute Options

The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.

Termination of This Group Plan

Santa Rosa Junior College may terminate this group *plan* at any time. When this *plan* ends, you may be eligible to continue your coverage. Your rights, if any, upon termination of the *plan* are explained in this benefit booklet.

Arrow Benefits Group

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