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# *Jackson County Self Funded Medical and Dental Plan*

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**Effective Date: July 1, 2009**

## **ABOUT THE PLAN**

Your Health Care Plan is provided by Jackson County. Claims-paying services and other administrative services for the Plan are performed on behalf of Jackson County by Wells Fargo Third Party Administrators, Inc. The Plan provides Medical, Prescription Drug, Vision and Dental Benefits.

## **YOUR RIGHTS AS A PARTICIPANT**

As a Plan Participant, you are protected by a federal law called the Employee Retirement Income Security Act of 1974 (ERISA). Your rights under the law are described in the Statement of ERISA Rights in your Medical and Dental handbook provided by Wells Fargo Third Party Administrators, Inc.

## **YOUR SUMMARY PLAN DESCRIPTION**

ERISA requires that all Plan Participants be given a Summary Plan Description, a brief summary of their Plan Benefits. This booklet is intended to fulfill that requirement. If your booklet is misplaced, you may get a replacement from your employer.

Your Summary Plan Description booklet is not a contract of insurance or a formal Plan Description. Complete information about the Plan is contained in the written Plan Description maintained by Jackson County.

This Summary Plan Description replaces and supersedes any and all previous benefit booklets or Summary Plan Descriptions. In the event of an inadvertent discrepancy between the information in this booklet and the actual provisions of the Plan, the terms of the written Plan Description will rule.

## SUMMARY OF BENEFITS

Plan for Employees who Participate in the Health Risk Assessment and  
Non-Tobacco user if hired on or after July 1, 2006

MEDICAL BENEFITS	In-Network	Out-of-Network
<b>Calender Year Deductible (when applicable)</b> • Individual • Family (2 Individuals)	\$500 Two times Individual	Two times In-Network Two times In-Network
<b>Per Confinement Copayment</b>	None	\$250
<b>Out-of-Pocket Maximum***</b> • Individual • Family • Payment rate after Out-of-Pocket is satisfied	\$2,500 Two times Individual 100%	Two time In-Network Two times In-Network 100% R&C
<b>Hospital Services</b> • Inpatient • Outpatient • Emergency Room (non-Emergency Services) • Emergency Room (Emergency Services) <i>Copayment waived if followed by Admission</i>	90%* 90%* 90%* 90% - \$75 Copay	80%* (**) 80%* 80%* 90% - \$75 Copay
<b>Physicians Services</b> • Primary Care Office Visits • Urgent Care Centers • Specialist Office Visits • Allergy Injections • Independent Laboratory Services • Other Services - Surgeons Fees, etc.	100% - \$15 Copay 100% - \$25 Copay 100% - \$25 Copay 100% - \$5 Copay 100% 90%*	100% R&C - \$25 Copay 100% R&C - \$25 Copay 80% R&C* 80% R&C* 80% R&C* 80% R&C*
<b>Wellness and Preventive Care Services • Pap Smears, Mammograms, PSA Screenings, Well Baby Care and Immunizations</b> • Primary Care Office Visits • Specialist Care Office Visits	100% - \$15 Copay**** 100% - \$15 Copay****	100% R&C - \$25 Copay 80% R&C*
<b>Ambulatory Surgical Facility Services</b>	90%*	80% R&C*
<b>Maternity Services</b> • OB/GYN Services ( <i>Copay maximum \$250 for Prenatal and Postpartum Visits</i> ) • Hospital Services	100% - \$25 Copay 90%*	80% R&C* 80% R&C*
<b>Ambulance Services</b> ( <i>Maximum Benefit of \$2000 per Participant per trip</i> )	80% R&C*	

\* Calender Year Deductible Applies

\*\* Per Confinement Copayment Applies

\*\*\* Certain expenses do not apply towards satisfaction of the Out-of-Pocket Maximum. See the MEDICAL BENEFITS Section for details.

\*\*\*\* Copayment is waived for mammograms received within 3 months before or after wellmess examination.

<b>Psychiatric Services</b> • Inpatient • Outpatient	80% R&C* 50% R&C*
<b>Substance Abuse Treatment Services</b> • Inpatient • Outpatient	80% R&C* 50% R&C*
<b>Outpatient Prescription Drugs</b> (PRx drug card program) NOTE: • Inpatient Prescription Drugs are covered under Ancillary Services and Supplies • Prilosec OTC is available with a prescription at the Generic Drug Copay level • Smoking Cessation over-the-counter drugs are available at the Generic Drug Copay level	\$10 Copay - Generic Drug \$35 - Brand Name Drugs, if no Generic available \$50 - Brand Name Drugs, if Generic available
<b>All Other Covered Services</b>	80% R&C*

\* Calender Year Deductible Applies

### VISION BENEFITS SUMMARY

<b>Calendar Year Maximum Benefit</b>	\$100 per Participant
<b>Plan Payment Rate</b>	100% Less \$25 Copay
<b>Covered Charges</b>	<ul style="list-style-type: none"> <li>• Eye examinations, including refractions</li> <li>• eyeglass lenses</li> <li>• eyeglass frames</li> <li>• contact lenses</li> </ul>

Plan for Employees who do not participate in the Health Risk Assessment or Users of Tobacco Products if hired on or After July 1, 2006

<b>MEDICAL BENEFITS</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Calendar Year Deductible</b> <i>(when applicable)</i> • Individual • Family (2 Individuals)	\$1,500 Two times Individual	Two times In-Network Two times In-Network
<b>Per Confinement Copayment</b>	\$250	\$250
<b>Out-of-Pocket Maximum</b> *** • Individual • Family • Payment rate after Out-of-Pocket is satisfied	\$5,000 Two time Individual 100%	Two times In-Network Two times In-Network 100% R&C
<b>Hospital Services</b> • Inpatient • Outpatient • Emergency Room (non-Emergency Services) • Emergency Room (Emergency Services) <i>Copayment waived if followed by Admission</i>	80%* (**) 80%* 80%* 90% - \$150 Copay	70%* (**) 70%* 70%* 90% - \$150 Copay

\* Calender Year Deductible Applies

\*\* Per Confinement Copayment Applies

\*\*\* Certain expenses do not apply toward satisfaction of the Out-of-Pocket Maximum. See the MEDICAL BENEFITS Section for details.

<b>Physicians Services</b> <ul style="list-style-type: none"> <li>• Primary Care Office Visits</li> <li>• Urgent Care Centers</li> <li>• Specialist Office Visits</li> <li>• Allergy Injections</li> <li>• Independent Laboratory Services</li> <li>• Other Services - Surgeon Fees, etc</li> </ul>	100% - \$25 Copay 100% - \$25 Copay \$50 Copay 80%* 80%* 80%*	100% R&C - \$30 Copay 100% R&C - \$30 Copay 70% R&C* 70% R&C* 70% R&C* 70% R&C
<b>Wellness and Preventative Care Services</b> <ul style="list-style-type: none"> <li>• Pap Smears, Mammograms, PSA Screenings, Well Baby Care and Immunizations <ul style="list-style-type: none"> <li>• Primary Care Office Visits</li> <li>• Specialist Care Office Visits</li> </ul> </li> </ul>	100% - \$25 Copay 100% - \$50 Copay	100% R&C - \$30 Copay 70% R&C
<b>Ambulatory Surgical Facility Services</b>	80%*	70% R&C*
<b>Maternity Services</b> <ul style="list-style-type: none"> <li>• OB/GYN Services</li> <li>• Hospital Services</li> </ul>	80%* 80%*	70% R&C* 70% R&C*
<b>Ambulance Services</b> ( <i>Maximum Benefit of \$2,000 per Participant per trip</i> )	80% R&C*	
<b>Psychiatric Services</b> <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient</li> </ul>	80% R&C* 50% R&C*	
<b>Substance Abuse Treatment Services</b> <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient</li> </ul>	80% R&C* 50% R&C*	
<b>Outpatient Prescription Drugs</b> (PRx drug card program) NOTE: <ul style="list-style-type: none"> <li>• Inpatient Prescription Drugs are covered under Ancillary Services &amp; Supplies</li> <li>• Prilosec OTC is available with a prescription at the Generic Drug Copay level</li> <li>• Smoking cessation over-the-counter drugs are available at the Generic Drugs Copay level</li> </ul>	\$10 Copay - Generic Drugs \$45 Copay - Brand Name Drugs, if no Generic available \$60 Copay - Brand Name Drugs, if Generic available	
<b>All Other Covered Services</b>	80% R&C*	

\* Calendar Year Deductible Applies

## VISION BENEFITS SUMMARY

<b>Calendar Year Maximum Benefit</b>	\$70 per Participant
<b>Plan Payment Rate</b>	100% Less \$25 Copay
<b>Covered Charges</b>	<ul style="list-style-type: none"> <li>• Eye examinations, including refractions</li> <li>• eyeglass lenses</li> <li>• eyeglass frames</li> <li>• contact lenses</li> </ul>

<b>MAXIMUM BENEFITS</b>	
Applicable to both of the above plans	
<b>Maximum Medical Benefit</b>	\$1,000,000
<b>Chiropractic Services</b>	\$500 Calendar Year Maximum
<b>Physical Therapy Services</b>	\$5,000 Calendar Year Maximum
<b>Home Health Care</b>	\$5,000 Calendar Year Maximum
<b>Psychiatric Services</b> • Inpatient • Outpatient	Limited to 10 days per Calendar Year Limited to 20 Visits per Calendar Year
<b>Substance Abuse Services</b> <i>Inpatient and Outpatient combined</i>	\$8,000 Calendar Year Maximum \$16,000 Plan Maximum

**DENTAL BENEFITS SUMMARY**  
Applicable to both above plans

<b>Covered Charges for:</b>	<b>Plan Payment Rate</b>
<b>Diagnostic and Preventative Services</b>	80% of Allowable Covered Charges
<b>Basic Services</b>	80% of Allowable Covered Charges
<b>Major Services</b>	50% of Allowable Covered Charges
<b>Orthodontic Services</b>	50% of Allowable Covered Charges
<b>Maximum Calendar Year Benefit</b> (not applicable to Orthodontia Services)	\$1,000 per Participant
<b>Maximum Orthodontic Benefit</b>	\$1,000 per Participant
<b>Calendar Year Deductible</b>	None

Applicable to Both Plans

For Employees whom participate in the Health Risk Assessment.

Mail in prescriptions for the employees that have hypertension, diabetes, high cholesterol, or use tobacco products the medications and supplies will be paid at \$0 Copay.

**DOCTORS DIRECT HEALTHCARE**

Telephone 1-877-503-0388 or (910) 485-0510

Fax 1-866-252-8232 or (910) 485-8662

**PRECERTIFICATION REQUIREMENTS  
for JACKSON COUNTY MEDICAL PLAN**

<b>BENEFITS &amp; SERVICES UTILIZATION REVIEW REQUIREMENTS</b>	<b>Precertification Requirement and Penalty for Noncertification</b>
<b>Inpatient Admissions (Non-emergency)</b> *Includes Medical, Mental Health, Chemical Dependency and Rehabilitation	<b>Precertification Required.</b> (If not obtained, benefits will be reduced by \$500 pending medical necessity approval)
<b>Inpatient Admissions (Emergency)</b> *Includes Medical, Mental Health and Chemical Dependency	<b>Notification Required within 2 business days of admission.</b> (If not obtained, benefits will be reduced by \$500 pending medical necessity approval)
<b>Surgery -- Outpatient</b>	<b>Precertification Required.</b> (If not obtained, benefits will be reduced by 50% pending medi- cal necessity approval)
<b>Skilled Nursing Facility Care</b>	<b>Precertification Required.</b> (If not obtained, benefits will be reduced by 50% pending medi- cal necessity approval)
<b>Private Duty Nursing</b>	<b>Precertification Required.</b> (If not obtained, benefits will be reduced by 50% pending medi- cal necessity approval)
<b>Transplants</b>	<b>Precertification Required.</b> (If not obtained, benefits will be reduced by 50% pending medi- cal necessity approval)
<b>Other Services:</b> Ambulance (non-emergency) Home Health, Hospice Home Infusion Therapy Physical Therapy (after initial evaluation) Occupational Therapy (after initial evaluation) Speech Therapy (after initial evaluation) Cardiac Rehab (after initial evaluation) Pulmonary Rehab (after initial evaluation) Adult MRI's (17 y.o. and older) Nuclear Medicine Study Sleep Study Sonorex/OssaTron Therapy Reconstructive/Plastic Surgery Oral Surgery/Medical Dental TMJ (surgery, splints, MRI, PT) Durable Medical Equipment Orthotics & Prosthetics	<b>Precertification Required.</b> (If not obtained, benefits will be reduced by 50% pending medi- cal necessity approval)  (DME/Medical Supplies /Orthotics & Prosthet- ics: Pre-Certification is required for all rentals. Purchases greater than \$500 will also require Pre-Certification.) **Please note - Nebulizers and Diabetic Sup- plies do not require precertification with excep- tion of Insulin Pumps.

\*Please contact the Medical Management Office at 1-877-503-0388 for questions regarding authori-  
zations or precertification requirements.

## MEDICAL EXCLUSIONS

*The following charges are not covered under the Plan:*

- Charges Incurred:
  - Before the Participant's effective date of coverage under the Plan; or
  - After the date the Participant's coverage under the Plan has ended.
- Charges applied to a Participant's Calendar Year Deductible.
- The portion of charges a Participant is required to pay due to application of the Plan Payment Rate.
- The first \$500 of charges for Inpatient Hospital Services when Pre-Admission certification is not obtained.
- Charges for which claims are filed more than 90 days after the date they were Incurred.
- Charges processed by Well Fargo Third Party Administrators, Inc after any applicable Maximum Benefit has been exhausted.
- Charges in excess of Allowable Covered Charges.
- Charges for Experimental/Investigative services or supplies, or which are required to treat routine complications of an Experimental/Investigative service.
- Charges for services or supplies that are not: (a) ordered or performed by a Doctor; or (b) Medically Necessary, unless specifically listed in the Covered Medical Charges provision of the Summary Plan Description.
- Charges for Hospital Room and Board: (a) in connection with Hospital Admissions for which Pre-Admission Review was requested but not granted; or (b) for Inpatient Hospital Services rendered on days in excess of the number of days certified by the Medical Management Program.
- Charges Incurred due to a Pre-existing Condition, unless:
  - The charges are Incurred after the date the Participant has been a Participant for 12 successive months; or
  - The Participant has evidence of prior Creditable Coverage to reduce the exclusion period for Pre-existing Conditions. In such case, Preexisting Conditions are excluded for the length of the Preexisting Condition Exclusion Period that is not reduced by prior Creditable Coverage.
- Charges for marital counseling, family counseling, educational therapy, behavior therapy, vocational therapy, coma-stimulation therapy, activities therapy, or recreational therapy. Recreational therapy includes, but is not limited to, play, sleep, dance, art, crafts, aquatic, hydro, gambling, and nature therapy.

## MEDICAL EXCLUSIONS (Continued)

- Separate charges for: (a) pre- and post-operative services in connection with Surgical Services; (b) anesthesia administered by the surgeon or assistant at Surgery; or (c) local infiltration anesthesia.
- Charges for Skilled Nursing Facility Services when the total covered expense for each day in the Skilled Nursing Facility exceeds half the semi-private room rate of the last Hospital where the patient was discharged for the same or a related condition; and Skilled Nursing Facility Services charges when the Confinement is chiefly for Custodial Care.
- Charges for Home Health Care Services which are not Incurred: (a) when the Participant is confined at home; and (b) immediately following a Hospital Confinement for the same Sickness or Injury.
- Charges submitted as charges for Home Health Care Services if the charges are for: (a) homemaker services; (b) maintenance therapy; (c) Dialysis Treatment; (d) purchase or rental of dialysis equipment; or (e) food or home-delivered meals.
- Charges for more than one Surgery performed during the same operation in excess of: (a) the amount payable for the primary procedure; plus (b) 50% of the amount that would have been payable for each of the next three procedures had they been performed alone. No Benefits are payable for procedures in excess of four.
- Charges for Surgical Services in excess of one surgeon's Allowable Covered Charges, if the Surgery was performed by two or more surgeons but could have been performed by one surgeon.
- Charges for x-rays or other examinations for an Inpatient which are not related to the diagnosis of the condition requiring the Inpatient Admission. These include chest x-rays and other examinations which a Hospital requires as part of its routine Admission procedure.
- Charges for Dental Services related to an Injury which occurred before the Participant's Effective Date of coverage under the Plan.
- Charges for treatment of any Sickness or Injury related in any way to the Participant's job when:
  - The Participant receives payment from his or her Employer on account of the Sickness or Injury;
  - The Participant's Employer is required by federal, state, or local laws or regulations to provide benefits to the Participant; or
  - The Participant could have received benefits for the Injury or Sickness if he or she had complied with the laws and regulations.

*This exclusion applies whether or not the Participant claims the benefits or compensation and whether or not the Participant recovers losses from a third party.*

## MEDICAL EXCLUSIONS (Continued)

- Charges for Outpatient Prescription Drugs.
- Charges to the extent any payment was provided or available:
  - Under a U.S. government program or a program for which a governmental entity pays all or part of the cost;
  - Under the Medicare program or under any similar program authorized by state or local laws or regulations or any future amendments to them, whether or not the Participant waives his or her rights under these laws, amendments, programs, or terms of employment.
- Charges for which a Participant would have no legal obligation to pay in the absence of the Plan or similar coverage.
- Charges for services or supplies received from a dental or medical department maintained by or on behalf of an employer, a mutual association, a labor union, a trust, or a similar person or group.
- Charges for Cosmetic Surgery or related services, including services for complications of Cosmetic Surgery. In determining whether Surgical Services are cosmetic or not, the Plan will not take into account the Participant's mental state.
- Charges for services rendered by a Doctor who is the Participant's Employer, coworker, spouse, child, sibling, or parent.
- Charges for personal hygiene and convenience items, including, but not limited to: (a) humidifiers; (b) air conditioners; or (c) physical fitness equipment.
- Charges for: (a) telephone Consultations; (b) failure to keep a scheduled appointment; or (c) completion of a claim form.
- Charges for rest cures, Residential Care, or Custodial Care.
- Charges for travel, even if prescribed by a Doctor.
- Charges Incurred during Inpatient Admissions primarily for observation or diagnostic studies, unless:
  - The Participant's medical condition requires that medical supervision by the attending Doctor be constantly available;
  - The Participant's medical condition requires that the skills of a licensed medical professional be constantly available; or
  - The Diagnostic Services and equipment required are available only on an Inpatient basis.
- Charges for services rendered to an Inpatient which might have been safely and adequately rendered in the Participant's home, the Doctor's office, or at any lesser level of institutional care.

## MEDICAL EXCLUSIONS (Continued)

- Charges for: (a) routine or periodic physical examinations; (b) school entry, work permit, insurance, or employment examinations; (c) screening examinations (including x-ray examinations made without film); (d) immunizations; and (e) other care not related to a specific Sickness or Injury which is known or reasonably suspected; except as provided by the Wellness and Preventive Services Benefit.
- Charges for dentistry or dental processes other than:
  - Dental Services, including pre- and post-operative care; and
  - Inpatient Hospital Services for a medical condition which might become life-threatening if the Participant were not hospitalized for a dental procedure. For example, if a Participant with hemophilia (a medical condition) needed to have an unimpacted tooth extracted, the Plan would cover Hospital Services needed to safeguard the patient against the bleeding that might occur as a result of the Participant's medical condition; however, charges for the extraction itself would not be covered.
- Charges Incurred during Hospital Admissions which are primarily for Physical Therapy that could have been rendered on an Outpatient basis.
- Charges for Physical Therapy to maintain motor functions, except when the Plan determines that there is a reasonable chance that the patient's motor functions will improve as a result of the therapy.
- Charges Incurred during a Hospital Admission for environmental change.
- Charges made separately for care by interns, residents, house Physicians, or other health care professionals who are employed by the Hospital which makes their services available.
- Charges for treatment of obesity or in connection with weight reduction or dietary control, whether or not an obesity-related medical condition exists, except for surgical treatment of morbid obesity when weight exceeds by at least 100 pounds or is at least twice the ideal weight specified for frame, age, height, and sex in the most recent Metropolitan Life Insurance tables.
- Charges for Surgery to correct nearsightedness.
- Charges made by a Hospital Incurred during a temporary absence from the Hospital.
- Charges for nutritional counseling and related services, except when provided as part of Home Health Care Services.
- Charges for educational or teachers' services.

## **MEDICAL EXCLUSIONS (Continued)**

- Charges for Organ Transplant Services, except as defined.
- Charges for Maternity Services rendered to a Dependent child.
- Charges for common first aid supplies or over-the-counter Medical Supplies.
- Charges Incurred due to: (a) autistic disease of childhood; (b) learning disabilities; (c) behavioral problems; (d) mental retardation; or (e) conduct and oppositional disorders.
- Charges for acupuncture.
- Charges for occupational or rehabilitative therapy if the primary purpose is to train the Participant for a new job.
- Charges for treatment of: (a) anti-social personality; (b) inadequate personality; (c) sexual deviation; (d) social maladjustment without apparent psychiatric disorder; or (e) group delinquent reaction of childhood.
- Charges for services or supplies, including Prescription Drugs, related to smoking cessation.
- Charges for hearing aids or their fitting, or for hearing exams.
- Charges for infertility treatment or infertility drugs.
- Charges for: (1) artificial insemination or in vitro fertilization; (2) treatment of sexual dysfunction not related to organic disease; or (3) surgical sex transformation and follow-up care.
- Charges for palliative or cosmetic foot care, including: (a) care for flat foot conditions; (b) supportive devices, including shoes inserts; (c) treatment of subluxation; (d) care of corns, calluses, toe nails, fallen arches, weak feet, or chronic foot strain; and (e) care for bunions, except capsular or bone Surgery.
- Charges for dorsal rhizotomy to treat spasticity.
- Charges for treatment of any Sickness or Injury resulting from: (a) any act of war (declared or undeclared); or (b) voluntary participation in civil disobedience.
- Charges for surgical trays (if charged separately).
- Charges for Doctors' after-hours services.

### **MEDICAL EXCLUSIONS (Continued)**

- Charges for abortion, except therapeutic.
- Charges for a provider not charging for services.
- Charges for: (1) vision training; (2) vision therapy; or (3) orthoptics.
- Charges for an Injury or Sickness resulting from commission of a felony or active participation in a riot.
- Charges for services or supplies not shown in the COVERED MEDICAL CHARGES Section.

## DENTAL EXCLUSIONS

*The following types of Dental Charges are not covered under the Dental Benefits section of the Plan:*

- Facility charges.
- Charge for Dental Services with respect to congenital or developmental malformation or primarily for cosmetic or aesthetic purposes except those described in the Plan.
- Charges for patient training in plaque control or other personal dental care instructions.
- Charges for Dental Services for which the Participant usually Incurs no charge.
- Charges for Dental Services received from a dental or medical department maintained by, or on behalf of, an employer, a mutual benefit association, a labor union, a trustee or similar person or group.
- Charges for routine examinations, prophylaxes and topical application of fluoride provided more than twice in a Calendar Year.
- Charges for complete mouth x-rays provided more frequently than once in a three-year period, unless special need is shown in a treatment plan submitted by the Dentist and approved in writing by the Plan.
- Charges for supplemental bitewing x-rays provided more than twice in a Calendar Year.
- Charges for care or treatment rendered or furnished after termination of coverage, except for procedures, as determined by the Plan, which are performed in states, such as root canals, crowns and bridges, when the procedure was in actual process prior to termination.
- Charges for dental implants.
- Charges for Sargenti procedure-paste fill root canal.
- Charges for occlusion analysis.
- Charges for local anesthesia, nitrous oxide, or intravenous sedative when billed separately from Dental Service (allowance for Dental Services include Benefits for local anesthesia, nitrous oxide or intravenous sedation).
- Charges for replacement of any full or partial, immediate (temporary) denture by another immediate denture.
- Charges for replacement of Prosthetic Appliances more often than once every five (5) Calendar Years.

## DENTAL EXCLUSIONS (Continued)

- Charges for replacement of fixed or removable bridgework, crowns or splints, or the replacement of any full or partial permanent denture by another permanent denture, if the cost of the original such appliance or restoration was paid, in full or in part, by the Plan unless a period of five (5) years has elapsed from the installation of such bridgework, denture, crowns or splints. However, Benefits will be paid for revision of an existing denture or bridge necessitated by extractions of one or more teeth supporting such appliance when the extraction occurs after the existing denture or bridge was installed.
- Charges for Dental Services when procedures are in actual process prior to commencement of coverage, except for monthly orthodontic fees Incurred after the effective date of dental coverage.
- Charges for Orthodontic Services Incurred by a Participant other than a covered child under 19 years of age.
- Charges not listed as Covered Dental Charges.
- Charges for which claims were filed more than 90 days after the date the charges were Incurred, unless evidence is provided to the Claims Administrator that: (a) it was not reasonably possible to submit the claim within that 90-day period; or (b) the Participant was unable to submit the claim within the 90-day period because he or she was legally incompetent.
- Charges processed by Wells Fargo Third Party Administrators, Inc after the Maximum Calendar Year Dental Benefit has been exhausted.
- Charges for the portion of the charges a Participant is required to pay due to the application of the Plan Payment Rate.
- Charges for space maintainers Incurred by Participants over age 19.
- Charges for application of fluoride Incurred by Participants over age 19.
- Charges for Orthodontic Services when the Course of Treatment covers a period of more than 36 months, unless the services are rendered during a new Course of Treatment which begins at least 5 years after the prior Course of Treatment.
- Charges for permanent crowns for Participants under age 16, unless approved in advance by the Plan.
- Charges for care by more than one Dentist if a Participant transfers from the care of one Dentist to another Dentist during the Course of Treatment.
- Charges for care by more than one Dentist if more than one Dentist renders services for one dental procedure.

## DENTAL EXCLUSIONS (Continued)

- Charges in excess of Allowable Covered Charges.
- Charges in excess of charges for the least costly services or supplies which meet sound professional standards and correct the dental Injury or oral disease being treated.
- Charges for services to correct or treat congenital or developmental malformation.
- Charge for services rendered for cosmetic purposes, except if required due to an accidental Injury sustained while the Participant is covered under the Dental Benefits section of the Plan.
- Charges for gold foil restorations.
- Charges for appliances or restoration necessary to increase vertical dimensions or restore or correct the occlusion.
- Charges for an appliance or a modification to an appliance, if an impression for it was made before the Participant became covered under the Dental Benefits section of the Plan.
- Charges for root canal therapy, if the pulp chamber for it was opened before the Participant became covered under the Dental Benefits section of the Plan.
- Charges for a crown, bridge, or gold restoration, if a tooth was prepared for it before the Participant became covered under the Dental Benefits section of the Plan.
- Charges for replacing lost or stolen appliances.
- Charges for services or supplies not provided by a Dentist.
- Charges for services or supplies that are Experimental/Investigative in nature.
- Charges for treatment of any Sickness or Injury resulting from: (a) any act of war (declared or undeclared); or (b) voluntary participation in civil disobedience.
- Charges for services rendered by a Dentist who is the Participant's: Employer; coworker; spouse; child; sibling; or parent.
- Charges covered under the Medical Benefits section of the Plan.
- Charges for: (a) telephone Consultations; (b) failure to keep a scheduled appointment; or (c) completion of a claim form.

## DENTAL EXCLUSIONS (Continued)

- Charges for treatment of any Sickness or Injury related in any way to the Participant's job when:
  - The Participant receives payment from his or her Employer on account of the Sickness or Injury;
  - The Participant's Employer is required by federal, state, or local laws or regulations to provide benefits to the Participant; or
  - The Participant could have received benefits for the Injury or Sickness if he or she had complied with the laws and regulations.

*This exclusion applies whether or not the Participant claims the benefits or compensation and whether or not the Participant recovers losses from a third party.*

- Charges to the extent any payment was provided or available:
  - Under a U.S. government program or a program for which a governmental entity pays all or part of the cost;
  - Under the Medicare program or under any similar program authorized by state or local laws or regulations or any future amendments to them, whether or not the Participant waives his or her rights under these laws, amendments, programs, or terms of employment.
- Charges Incurred: (a) before the Participant's Effective Date of coverage; or (b) during an Inpatient Admission that began before the Participant's Effective Date of coverage.
- Charges Incurred after the date a Participant's coverage ends.

MEDICAL RATES 07/01/2007 thru 06/30/2008	NEW MONTHLY RATES	EMPLOYEE BI-WEEKLY RATE
Individual	\$652.18	No Cost to You
Employee/ Child	\$850.91	\$91.72
Employee/ Children	\$947.92	\$136.50
Employee/ Spouse	\$947.92	\$136.50
Family	\$1,063.24	\$189.72

DENTAL RATES 07/01/2007 thru 06/30/2008	NEW MONTHLY RATES	EMPLOYEE BI-WEEKLY RATE
Individual	\$11.82	No Cost to You
Employee/ Child	\$20.31	\$3.92
Employee/ Children	\$24.43	\$5.82
Employee/ Spouse	\$24.43	\$5.82
Family	\$29.39	\$8.11