



# Cingular Wireless Dental Plan for Bargained Employees

## *Summary Plan Description*



This "Summary Plan Description" or "SPD" is effective for claims incurred on or after January 1, 2005. For claims incurred prior to that date, the SPD dated November 1, 2001 together with any "Summaries of Material Modification" or "SMMs" shall govern.



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## Overview

This “Summary Plan Description” or “SPD” is effective for claims incurred on or after January 1, 2005. For claims incurred prior to that date, the SPD dated November 1, 2001 together with any “Summaries of Material Modification” or “SMMs” shall govern.

The Cingular Wireless Dental Benefits for Bargained Employees (“Dental Plan”) of the *Cingular Wireless Health and Welfare Benefits Plan for Bargained Employees* encourages regular dental checkups and proper care of your teeth. Delayed dental care may cause unnecessary pain and may also mean more extensive treatment, often at high costs. The Dental Plan pays certain preventive and diagnostic care expenses so you can maintain good dental health. It also helps you pay for other dental treatments which may become necessary.

All care must be provided by a licensed dentist or orthodontist.

### National Bargained Plan

Employees may choose between two options of the Dental Plan – a Fee for Service Dental Plan or a Dental Health Maintenance Organization (“DHMO”). You may choose the Fee for Service option and use any licensed dentist. If you choose the DHMO option you must use your assigned DHMO provider.

### SNET

Dental benefits are provided under a Preferred Provider Plan. You may use dentists who are members of the PPO network or any licensed dentist; however for many services your reimbursement will be higher if you use a PPO network dentist.

This Summary Plan Description (“SPD”) is intended to provide a summary of the major provisions of the Dental Plan and does not attempt to cover all details. *The Cingular Wireless Health and Welfare Benefits Plan for Bargained Employees* is the official Plan Document (“Plan Document”), the final authority and, in the event of a conflict with this SPD, shall govern in all cases. The *Other Important Information* section contains other provisions governing the Dental Plan. You should read that section in conjunction with this SPD.

The Company intends to continue this Dental Plan indefinitely but reserves the right, subject to applicable collective bargaining agreements, to terminate, amend, change or modify this Dental Plan, retroactively or prospectively, in full or in part at any time or for any reason, including changes in any or all of the benefits provided. See the *Other Important Information* section for more information regarding Plan amendment and termination.



## Contact Information

### **Cingular Wireless Benefits Service Center**

Telephone: 1-877-421-5225

Cingular Wireless Intranet Site: My Cingular/Human Resources/NetBenefits

Internet: [netbenefits.fidelity.com](http://netbenefits.fidelity.com)

### **Claims Administrator**

**(predetermination, claims processing, network directories)**

CIGNA

P.O. Box 188041

Chattanooga, TN 37422

Telephone: 1-888-919-5225

**(appeals)**

CIGNA

P.O. Box 188044

Chattanooga, TN 37422

## Common Terms

Certain terms used in this SPD beginning with a capital letter (such as Employee or Dependent) are defined in the *Eligibility, Enrollment and Other Administrative Provisions* section. The Plan Document legally governs the operation of the Plan and is the final authority on the meaning of the terms of the Dental Plan.

## Eligibility

See the *Eligibility, Enrollment and Other Administrative Provisions* section.

## Enrollment and Effective Dates

See the *Eligibility, Enrollment and Other Administrative Provisions* section.

## Annual Enrollment

See the *Eligibility, Enrollment and Other Administrative Provisions* section.

## Changes in Coverage or Enrollment

See the *Eligibility, Enrollment and Other Administrative Provisions* section.

## Contributions

See the *Eligibility, Enrollment and Other Administrative Provisions* section.



## When You Take a Leave of Absence

See the *Eligibility, Enrollment and Other Administrative Provisions* section.

## When You Are Disabled

See the *Eligibility, Enrollment and Other Administrative Provisions* section.

## If You Die

See the *Eligibility, Enrollment and Other Administrative Provisions* section.

## When Coverage Ends

See the *Eligibility, Enrollment and Other Administrative Provisions* section.

### **Dental Benefits Extension**

Even after your coverage ends, however, the Dental Plan will pay the scheduled amounts for the following items:

- Prosthetic devices such as dentures or fixed bridgework, if the dentist took the impressions and prepared the abutment teeth while the patient was covered and installs the device within three calendar months after coverage ends;
- A crown, if the dentist prepared the tooth while the patient was covered and installs the crown within three calendar months after coverage ends;
- Root canal therapy, if the dentist opened the pulp chamber of the tooth while the patient was covered and completes the treatment within three calendar months after coverage ends.

## Definitions

**Medically Necessary**...the treatment provided by your doctor or provider deemed to be necessary for preventive care or the diagnosis and treatment of a medical or dental condition and provided based on generally accepted medical or dental practice. The Medically Necessary determination made by the Claims Administrator may limit your benefits.

**Reasonable and Customary or R&C**...the fees charged by your doctor or the provider to the majority of patients for a similar service that fall within the range of usual fees charged by doctors or providers with similar training and experience for the same or similar service with the same geographical area. The Reasonable and Customary determination made by the Claims Administrator may limit your benefits.



## Summary of Benefits – National Bargained Plan

Employees covered under the National Bargained Plan may choose between two options of the Dental Plan – a Fee for Service Dental Plan or a Dental Health Maintenance Organization (“DHMO”). **You and your Dependents are all covered under the option you select for the full calendar year unless you have a family status change or address change that permits you to change coverage.** Your family membership (consisting of you and all your Dependents) cannot be divided between the two options.

You may choose the Fee for Service option and use any licensed dentist. If you choose the DHMO option you must use only your assigned DHMO provider.

If you elect coverage with the DHMO, you are subject to the benefits, terms and limitations of the DHMO, including the DHMO’s claims appeal process. For more information about the DHMO option, contact the DHMO Claims Administrator for a copy of the DHMO’s insurance certificate/booklet.

This section of the SPD is a brief description of the Fee for Service option and does not attempt to cover all the details of the Dental Plan. Specific details are included in the official Plan text that regulates the operation of the Dental Plan. The *Cingular Wireless Health and Welfare Benefits Plan for Bargained Employees* legally governs the operation of the Plan and is the final authority on the terms of the Plan.

If you elect to receive benefits under the Fee for Service option:

- You or your Dependents may receive dental services from any licensed dentist;
- This option pays 100% of the R&C charges for certain preventive and diagnostic care. Services to restore or replace natural teeth are also covered but may require you to pay a deductible and to share the cost of services provided;
- This option has a maximum benefit level each calendar year for you and each of your eligible dependents. In addition, the option has a lifetime maximum for orthodontia benefits. Orthodontia benefits don’t count toward the calendar-year maximum;
- For a specific list of covered services and the benefits payable by the Fee for Service option, see the “Covered Expenses” section.

## Covered Expenses

The following pages list some of the most frequently used services covered by the Fee for Service option and show examples of typical benefit levels. You are responsible for any amount above the R&C, and for all amounts after your benefits exceed any applicable calendar-year maximum per covered individual.

Certain services are not covered. See “Expenses Not Covered” and “Benefit Payment Limitations” sections for details.

HMO Participants: if your HMO covers dental services that are eligible expenses under the Dental Plan, the Dental Plan may cover any copays you make for those services.



Covered Service or Plan Feature	Fee for Service Option (Subject to R&C)
<b>Annual Deductible</b>	\$25
<b>Annual Maximum</b>	\$1,300
<b>Type A Expenses</b>  <b>Preventive Services Including:</b> <ul style="list-style-type: none"> <li>• Oral exams</li> <li>• Teeth cleaning and polishing</li> <li>• Periodontal maintenance procedures</li> <li>• Topical fluoride application</li> <li>• Space maintainers and their adjustment (for dependents only under age 19)</li> <li>• Sealants (permanent molars only)</li> </ul>	100% up to 2 per calendar year 100% up to 2 per calendar year 100% up to 4 per calendar year 100% up to 1 per calendar year  100% 100% One per tooth every 3 calendar years
<b>X-Rays</b> <ul style="list-style-type: none"> <li>• Bitewing (only one if full mouth taken in the same year)</li> <li>• Full mouth/Panoramic</li> <li>• For diagnosis</li> </ul>	100% up to 2 per calendar year 100% One every 3 calendar years 100%
<b>Type B Expenses</b>  Amalgam (silver) fillings – One surface, primary Root canal therapy (anterior canal) Root canal therapy (bicuspid) Root canal therapy (molar) Osseous surgery (1-3 teeth per quadrant) Osseous surgery (4 or more teeth per quadrant) Periodontal scaling and root planing (per quadrant) Denture adjustments (complete) Denture repairs (repair of complete denture base) Extractions (single tooth, erupted) Crowns (porcelain fused to precious metal) Crowns (resin with precious metal)	<b>Fee for Service Option (Type B and Orthodontia Expenses are subject to Schedule of Benefits – not R&amp;C)</b>  \$34.00* \$226.00* \$306.00* \$390.00* \$183.00* \$365.00* \$81.00* \$31.00* \$58.00* \$66.00* \$372.00* \$355.00*
<b>Orthodontia</b> Lifetime Maximum	\$1,400
Diagnostic treatment (orthodontic workup) First month of active treatment (initial banding) Active treatment visit (after first month) Retention visit Removable appliance therapy	\$144.00* \$711.00* \$89.00* N/A \$235.00*

\*Subject to deductible



## Predetermination of Benefits

Predetermination of benefits allows you to know in advance what payments will be made before any work is done.

The predetermination of benefits lets you and your dentist know ahead of time what charges the Dental Plan will cover and what you will have to pay. The final decision regarding treatment is up to you.

Take the following steps if your dentist proposes treatment that will cost **\$200 or more**:

**STEP 1.** The dentist itemizes the services and charges on a dental claim form and informs the Claims Administrator of the proposed course of treatment.

**STEP 2.** The Claims Administrator determines the amount the Plan will pay. Your dentist will be informed of the decision. Only the dentist will receive an EOB on predeterminations.

**STEP 3.** You and your dentist discuss the results and decide if and when the work will be done.

If your dentist submits a treatment plan for predetermination and then changes the treatment plan, the Claims Administrator will adjust its payments accordingly. If the dentist makes a major change in the treatment plan, the dentist should send in a revised plan. Please contact the Fee-for-Service Claims Administrator for dental claim forms or access these forms at [MyCigna.com](http://MyCigna.com).

### **Alternative Dental Procedures**

Often there is more than one way to treat a particular dental problem. For example, either a crown or filling could be used to restore a tooth. Also, choices can be made in materials to be used, for example, precious metal or plastic.

By submitting a predetermination of benefits request, you and your dentist can understand what the Claims Administrator considers the most economical way to treat a particular dental problem. In determining the most economical way for treatment, the Claims Administrator will use its dental consultant for major restorative procedures. (Note: Minor procedures may be auto-determined.)

If you and your dentist decide upon a more costly treatment, then you are responsible for the additional charges beyond those for the less costly appropriate treatment approved by the Claims Administrator.

## Exclusions and Limitations

The limitations and exclusions set forth below and throughout this document are not intended in any way to be exhaustive. The Dental Plan reserves the right to limit or exclude other services and supplies and the applicable charges that are determined to be inappropriate in the sole discretion of the Claims Administrator.

### **Benefit Payment Limitations**

Payments for your covered expenses are based on the actual charges of the dental care provider. However, the Plan will consider for payment only the R&C for Type A Services and the Schedule of Benefits for Type B Services.



Any portion of the covered expense that is above the R&C is an ineligible expense and will not be reimbursed. Expenses above the R&C also are not applicable toward your deductible. For example, if a dentist's fee is \$100 and the Claims Administrator determines that \$80 is the R&C for the service, the amount considered for payment is \$80. The excess, \$20 in this case, is not eligible for Dental Plan benefits.

A licensed dentist must provide care. Expenses must be Medically Necessary for preventive care or the diagnosis and treatment of a dental condition and provided based on generally accepted dental practice.

In considering the amount of plan benefits you can receive, the Claims Administrator will consider the most economical way to treat a particular dental problem.

### **Expenses Not Covered**

The Dental Plan is designed to cover the costs of good dental hygiene and repair. However, charges for some types of dental work are not covered, including but not limited to the following:

- Charges for services or supplies that exceed the R&C charges or exceed the maximum allowable expense;
- Work done primarily for cosmetic purposes, such as veneers, tooth whitening, porcelain facings on crowns and pontics behind the second bicuspid as well as charges for personalization of dentures;
- Services that begin before a person's effective date of coverage or after coverage has ended, except as specifically provided under "When Coverage Ends";
- Replacement of teeth removed before coverage is effective;
- Replacement of lost or stolen prosthetic appliances;
- Extra sets of dentures or other appliances;
- Services or supplies for which there is no legal obligation to pay or for which no charge would be made in the absence of plan benefits;
- Charges paid or payable in accordance with the laws of any foreign or domestic government;
- Services or supplies available from or covered by any governmental agency or plan;
- Charges for services or supplies not Medically Necessary for treatment of an injury or disease;
- Charges for broken appointments when no emergency prevented the person from canceling the appointment 24 hours in advance;
- Charges for completion of claim forms or filing of claims;
- Charges for sterilization or tray charges when billed separately;
- Implantology (implants)—a surgical implant of any type including any prosthetic device attached to it (i.e., crowns, bridges, etc.);
- Treatment of an injury, illness or disease caused by service in the armed forces of any government or by an act of war, declared or undeclared, including armed aggression, riot and insurrection, unless such person is on Cingular business, including travel, assignment and relocation outside of the United States;



## Exclusions and Limitations (cont.)

- Charges for services or supplies needed as a result of an injury, illness or disease arising out of the participation in or attempt to commit a felony or assault;
- Treatment resulting from a job-related accidental injury which is payable under your company's disability benefits plan;
- Charges for services or supplies payable under Workers' Compensation or similar laws;
- Periodontal splinting;
- Appliances, restoration and procedures to alter vertical dimension;
- Charges for local anesthetics and anesthetic supplies when billed separately;
- Charges for nitrous oxide (laughing gas);
- Prescription or nonprescription drugs or their administration;
- Charges for services generally considered experimental, developmental or investigatory treatment;
- Treatment for problems of the jaw joint including craniomandibular disorders, for example, temporomandibular joint syndrome (Note: Some treatments for temporomandibular joint syndrome are covered, see the Schedule of Benefits);
- Initial placement of partial or full removable dentures, removable bridge or fixed bridgework, if it includes replacement of one or more natural teeth missing before coverage was effective;
- Replacement of an existing partial denture, full removable denture or fixed bridgework, unless it is at least five years old and cannot be repaired or otherwise made serviceable;
- Any appliances or procedures if preparations for that appliance or procedure were begun before coverage became effective;
- Charges for a more costly dental procedure when a more economical method of treatment meets acceptable dental standards as determined by the Claims Administrator;
- Services or supplies to the extent paid in whole or in part by any other health plan of your company or by an HMO;
- Charges for dental services provided by a physician for treatment of accidental bodily injury to natural teeth which occurred while covered by the Plan that are eligible for payment under medical plan benefits;
- Charges for any hospital services or supplies;
- Services or supplies provided other than those under the Plan;
- Educational or training programs;
- Dietary instructions;
- Oral hygiene instructions and plaque control programs; and
- General anesthesia and IV sedation except when medically necessary in connection with oral surgery.



# How to File a Claim for Dental Care

## Claims Procedures

Claims must be submitted within one year after the dental services were provided.

To file a claim, follow the steps shown below.

**STEP 1.** Obtain a Dental Claim Form and complete part 1.

**STEP 2.** Have your dentist complete part 2. You sign the form and forward it to the Claims Administrator at the address shown on the form.

**STEP 3.** The check will be sent to the provider if you elect to have the provider paid directly. If not, you will pay the provider first and then be reimbursed. An Explanation of Benefits (EOB) will be sent to you. Keep the EOB for your files.

## One Year Claim Filing Limitation

Claims must be filed within a year of the date of service. Claims submitted past the filing date will not be considered for reimbursement.

## Coordination of Benefits

See the *Eligibility, Enrollment and Other Administrative Provisions* section.

## Summary of Benefits – SNET

Dental benefits are provided under a Preferred Provider Plan. You may use dentists who are members of the PPO network or any licensed dentist; however, for many services your reimbursement will be higher if you use a PPO network dentist.

## Covered Expenses

All reimbursements are based on the network negotiated charges or R&C charges.

Covered Service or Plan Feature	Within the CIGNA PPO Network	Outside the CIGNA PPO Network
<b>Annual Maximum</b>	\$1,400 per person (Combined maximum in- and out-of-network)	
<b>Deductible</b> (Applicable to Type B services only)	\$25.00 per person	
<b>Type A Expenses (Diagnostic and Preventive)</b>		
• Oral exams (2 per year)	100%	100%
• Routine cleanings (2 per year)	100%	100%



## Covered Expenses (cont.)

Covered Service or Plan Feature	Within the CIGNA PPO Network	Outside the CIGNA PPO Network
<p><b>X-Rays</b> Full-mouth x-rays covered but not more often than every three calendar years. Supplementary bitewing x-rays covered but not more often than twice in a calendar year.</p>	100%	100%
<p><b>Fluoride Application</b> Topical application of fluoride up to two treatments per year</p>	100%	100%
<p><b>Sealants</b> Two per lifetime, children through age 14</p>	100%	\$15.00
<p><b>Space Maintainers</b> (For eligible dependent children under age 19 only.) Fixed or removable designed to maintain existing space by preventing adjacent or opposing teeth from moving only when these appliances replace lost or extracted teeth. Subsequent adjustment of these appliances when required because of a relative change in the condition of the mouth.</p>	100%	100%
<b>Type B Expenses (Subject to the Deductible)</b>		
<b>Minor Restorative</b>		
Amalgam (silver) fillings	80%	70%
Root canal therapy	80%	70%
Osseous (bone) surgery	80%	70%
Periodontal scaling and root planing (per quadrant)	80%	70%
Extractions (single tooth, erupted)	80%	70%
<b>Type B Expenses (Subject to the Deductible)</b>		
<b>Major Restorative</b>		
Denture (complete)	60%	50%
Bridges	60%	50%
Crowns (Porcelain fused with gold)	60%	50%
Crowns (Resin fused with high noble metal)	60%	50%



Covered Service or Plan Feature	Within the CIGNA PPO Network	Outside the CIGNA PPO Network
<b>Orthodontia</b>		
Lifetime Maximum	\$1,500 (Combined maximum in- and out-of-network)	
Diagnostic treatment (orthodontic workup)	100%	100%
First month's active treatment (initial banding)	100%	100%
Active treatment visits (after the first month)	100%	100%
Retention visit	100%	100%
Removable appliance therapy	100%	100%

## Predetermination of Benefits

Predetermination of benefits allows you to know in advance what payments will be made before any work is done. Predetermination is not required but the predetermination of benefits lets you and your dentist know ahead of time what charges the Dental Plan will cover and what you will have to pay. The final decision regarding treatment is up to you. You may utilize the predetermination process for any service but it is recommended if your dentist proposes treatment that will cost \$200 or more.

Take the following steps to initiate the predetermination of benefits process:

**STEP 1.** The dentist itemizes the services and charges on a Dental Claim Form and informs the Claims Administrator of the proposed course of treatment.

**STEP 2.** The Claims Administrator determines the amount the Plan will pay. Your dentist will be informed of the decision.

**STEP 3.** You and your dentist discuss the results and decide if and when the work will be done.

If your dentist submits a treatment plan for predetermination and then changes the treatment plan, the Claims Administrator will adjust its payments accordingly. If the dentist makes a major change in the treatment plan, the dentist should send in a revised plan. Please contact the Claims Administrator for dental claim forms.

## Alternative Dental Procedures

Often there is more than one way to treat a particular dental problem. For example, either a crown or filling could be used to restore a tooth. Also, choices can be made in materials to be used, for example, precious metal or plastic.

By submitting a predetermination of benefits request, you and your dentist can understand what the Claims Administrator considers the most economical way to treat a particular dental problem. In determining the most economical way for treatment, the Claims Administrator will use its dental consultant.

If you and your dentist decide upon a more costly treatment, then you are responsible for the additional charges beyond those for the less costly appropriate treatment approved by the Claims Administrator.



## Exclusions and Limitations

The limitations and exclusions set forth below and throughout this document are not intended in any way to be exhaustive. The Dental Plan reserves the right to limit or exclude other services and supplies and the applicable charges that are determined to be inappropriate in the sole discretion of the Claims Administrator.

### ***Benefit Payment Limitations***

Payments for your covered expenses are based on the actual charges of the dental care provider. However, the Plan will consider for payment only the R&C for certain services.

Any portion of the covered expense that is above the R&C is an ineligible expense and will not be reimbursed. Expenses above the R&C also aren't applicable toward your deductible. For example, if a dentist's fee is \$100 and the Claims Administrator determines that \$80 is the R&C for the service, the amount considered for payment is \$80. The excess, \$20 in this case, is not eligible for Dental Plan benefits.

A licensed dentist must provide care. Expenses must be necessary for preventive care or the diagnosis and treatment of a dental condition and provided based on generally accepted dental practice.

In considering the amount of plan benefits you can receive, the Claims Administrator will consider the most economical way to treat a particular dental problem.

### ***Expenses Not Covered***

- Anesthesia except general anesthesia when Medically Necessary;
- Appliances, restorations and procedures to alter vertical dimension;
- Canceled appointments for which you are charged;
- Charges for equipment and services used by your dentist or other dental provider for himself or herself or for services rendered to his or her immediate family, including parents, spouse and children;
- Costs for Type A services above the R&C when services are provided by a non-network dentist;
- Cost for Type B services above R&C;
- Drugs or their administration;
- Educational training programs, dietary instructions and plaque control programs;
- Experimental procedures;
- Extra sets of dentures or other appliances;
- Implantology – Implants of any type including any prosthetic device attached (i.e., crowns, bridges, etc.);
- Periodontal splinting;
- Prosthetic services are not covered for third molars (wisdom teeth);
- Replacing lost or stolen prosthetic appliances;



- Replacement of teeth removed before coverage is effective, except:
  - The replacement of existing or partial dentures, full removable dentures, and fixed bridgework is a covered expense if the existing denture or bridgework cannot be made serviceable and was installed at least five years prior to its replacement, and
  - The replacement of a denture or bridgework because of additional extractions while you are covered by the Plan.
- Services performed for cosmetic reasons;
- Services covered by any other SNET health plan;
- Services or supplies not Medically Necessary for proper dental care;
- Services performed while not covered under this plan;
- Services performed free of charge to patients;
- Services payable under Workers' Compensation or similar law;
- Services, supplies and treatment to the extent that they are more than either the applicable contracted fee, applicable R&C or applicable scheduled amount;
- Services, supplies and treatment that do not meet the dental practice standards accepted by the American Dental Association.

## How to File a Claim for Dental Care

### **Claims Procedures**

You must file a claim if you use a non-network dentist. If you use a network dentist, you do not have to file a claim form; your dentist will do that for you.

Claims must be submitted within one year after the dental services were provided.

To file a claim, follow the steps shown below. You will receive an Explanation of Benefits form once your claim has been processed. Additional forms may be obtained by calling the Claims Administrator.

**STEP 1.** Obtain a Dental Claim Form and complete part 1.

**STEP 2.** Have your dentist complete part 2. You sign the form and forward it to the Claims Administrator at the address shown on the form.

**STEP 3.** The check will be sent to the provider if you elect to have the provider paid directly. If not, you will pay the provider first and then be reimbursed. An Explanation of Benefits (EOB) will be sent to you. Keep the EOB for your files.



## **Coordination of Benefits**

See the *Eligibility, Enrollment and Other Administrative Provisions* section.

## **Overpayment**

See the *Eligibility, Enrollment and Other Administrative Provisions* section.

## **Right of Recovery**

See the *Eligibility, Enrollment and Other Administrative Provisions* section.

## **Unclaimed/Uncashed Benefit Payments**

See the *Eligibility, Enrollment and Other Administrative Provisions* section.

## **Plan Administration**

See the *Eligibility, Enrollment and Other Administrative Provisions* section.

## **Your Rights Under ERISA**

As a participant or a Dependent of a participant in the Dental Plan, you have rights under the Employee Retirement Income Security Act (ERISA). For more information, see the *Other Important Information* section.

## **How to File an Appeal**

See the *Other Important Information* section.