

**Plan Document  
of the  
Defined Benefit  
Self-Funded Health  
Care Plan**

**of  
XYZ Company**

**Effective July 1, \_\_\_\_\_**

# Part IV

# Other Benefits

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# DENTAL CARE BENEFITS

## Introduction

If a Covered Person incurs *Covered Dental Expenses* as set forth below, such Covered Person will be paid benefits subject to the following provisions. These benefits will be equal to the applicable percentage of the amount by which Covered Dental Expenses in any Benefit Year exceed the applicable deductible amount. The applicable *Copayment Rates* and the applicable *Deductible Amounts*, as specified in the Schedule of Benefits, will be determined separately for each Covered Person. The Deductible Amount has no relationship to any other deductible in the Plan. In addition to the individual Deductible Amount, there may also be a *Maximum Family Deductible*, as set forth in the Schedule of Benefits.

## Maximum Benefits

The maximum benefits for each Covered Person are shown in the Schedule of Benefits. Not more than the applicable *Maximum per Benefit Year* will be paid for expenses incurred for any Covered Person in a Benefit Year. Not more than the applicable *Lifetime Maximum Benefit* will be paid for expenses incurred for any Covered Person in all benefit years.

## Covered Dental Expenses

The following types of dental procedures are Covered Dental Expenses, provided the procedures are necessary and are performed or prescribed by a dentist, excluding any charges for procedures in excess of the *reasonable and customary charges*, as defined below, and subject to the Limitation on Covered Dental Expenses and the Exclusions herein.

The term *reasonable and customary charge* means the lowest of (i) the usual charge by the dentist or other provider of the services or supplies for the same or similar services or supplies, (ii) the usual charge of most other dentists or other providers of similar training or experience in the same geographic area for the same or similar services or supplies, and (iii) the actual charge for the services or supplies.

## Type A Expenses

1. Oral examinations, not more than twice in a calendar year.
2. X-rays
  - bitewing X-rays, not more than twice in a calendar year.
  - full mouth X-rays, once in a thirty-six (36) consecutive month period (includes Panorex).
3. Preventive treatment, consisting of:
  - Oral Prophylaxis - (cleaning and scaling of teeth) but not more than twice in a calendar year.

- Topical Fluoride Treatment - available only to Covered Person under nineteen (19) years of age, but, in any event, not more than one treatment in a calendar year.
  - Sealants - (materials, other than fluoride) for participants and covered dependents. (One application, posterior teeth only and limited to covered dependents under age 16.)
4. Space Maintainers.
  5. Study Models.

### **Type B Expenses**

1. Fillings.
2. Root canal therapy.
3. Oral surgery.
4. Administration of General Anesthetics when medically necessary and administered in connection with oral surgery or substances or agents which are administered to produce a state of sedation or relaxation or to reduce or eliminate pain while the patient is conscious.
5. Extractions.
6. Periodontal treatment.
7. Emergency palliation treatment.

### **Type C Expenses**

1. Inlays, onlays, dentures, bridgework and crowns (except as a substitute for TMJ surgery).
2. Repair or re-cementing of crowns, inlays, dentures, or bridgework.
3. Periodontal surgical services.

### **Type D Expenses**

Orthodontics treatment consisting of appliance therapy or surgical therapy for dependent children under 19 years of age.

Orthodontics Services. Necessary orthodontics services performed by a dentist (which are not considered covered dental expenses under any other section of this benefit) provided that the total benefit payable for all orthodontics service expenses incurred by an individual during any

dependent child's lifetime shall not exceed the *Lifetime Individual Orthodontia Maximum* as shown in the Schedule of Benefits.

Maximum, as set forth in the Schedule of Benefits. The reasonable expenses for orthodontics services are subject to the *Deductible Amount* and *Copayment Rate*, as shown in the Schedule of Benefits. Orthodontics services shall not be covered which are performed in connection with a series of services that commenced prior to the effective date of a dependent child's dental expense benefits. A charge will be deemed incurred on the date the service is received or rendered.

Special Note. In calculating the benefit payment for orthodontics services, the charge allowable for the initial fee will be limited to one-third of the total fee for the complete Orthodontics Treatment Plan. The payment on the balance of the orthodontics treatment plan will be prorated over the projected period of treatment. The fee of only one orthodontist will be allowed during one period of orthodontics treatment.

## **Exclusions**

Expenses in connection with for following are not Covered Dental Expenses:

1. Charges incurred for services rendered prior to the date coverage is effective or after coverage terminates.
2. Treatment other than by a licensed dentist or licensed physician except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed by the dentist.
3. Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.
4. Replacement of a lost, missing, or stolen prosthetic device.
5. Replacement or repair of an orthodontics appliance.
6. Any services which are covered by any Workers' Compensation or similar laws, or services which an Employer is required by law to furnish in whole or in part.
7. Services rendered through a medical department, clinic or similar facility provided or maintained by the Covered Person's employer.
8. Services or supplies for which no charge is made that the Covered Person is legally obligated to pay or for which no charge would be made in the absence of dental expense coverage.
9. Services or supplies which are not necessary, according to accepted standards of dental practice.

10. Services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature.
11. Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.
12. Any duplicate prosthetic device or any other duplicate appliance.
13. A plaque control program (a series of instruction on the care of the teeth).
14. Oral hygiene and dietary instruction, except as may otherwise be covered as indicated in the Schedule of Benefits.
15. Periodontal splinting.
16. Services to the extent that such services, or benefits for or because of such services, are otherwise provided under the Plan or under any other plan which the Employer contributes to or otherwise sponsors.
17. Myofunctional therapy, or correction of harmful habits.
18. Implantology.
19. Charges associated with the initial installation of dentures or bridgework replacing a tooth or a group of teeth, which were lost prior to the effective date of coverage.
20. Charges associated with the replacement of dentures, partial dentures, bridgework, or crowns not over five (5) years old.

These benefits are also subject to other plan provisions including but not limited to Eligibility, Claim Procedures, Extended Coverage, Coordination of Benefits, Continuation of Coverage and Pre-existing Conditions.

## **Proof of Claim**

Written proof covering fully the covered dental expense for which the claim is made must be submitted to the Plan Administrator within the claim filing period shown in the Schedule of Benefits after the day in which the dental expenses were incurred. Failure to furnish proof within the time provided shall not invalidate or reduce any claim if it is shown not to have been reasonable possible to furnish proof within a specified time and that proof was furnished as soon as was reasonable possible.

As part of the basis for determining benefits payable, the Plan Administrator may also require submission of X-ray and other appropriate diagnostic and evaluative materials. When these materials are unavailable and to the extent that verification of Covered Dental Expenses cannot reasonable be made by the Plan Administrator, based on the information available, benefits for

the course of treatments may be for a lesser amount than that which otherwise would have been paid.

## **Benefits after Termination of Coverage**

The Plan will not pay for services or supplies furnished after the date of termination of coverage. However, benefits on account of covered dental expenses incurred for the following procedures will be paid as though the coverage had continued in force:

1. A prosthetic device (such as full or partial dentures) if the dentist took the impressions and prepared the abutment teeth while the Covered Person was covered under the Plan, and delivers and installs the device within two (2) months following cessation of coverage.
2. A crown if the dentist prepared the tooth for the crown while the Covered Person was covered under the Plan, and installs the crown within two (2) months following cessation of coverage.
3. Root canal therapy if the dentist opened the tooth which the Covered Person was covered under the Plan, and completes the treatment within two (2) months following cessation of coverage.

# SHORT TERM DISABILITY BENEFITS

## Benefits Payable

Benefits, as determined by the *Benefit Formula*, and for the period of disability following the *Waiting Period*, as shown in the Schedule of benefits, will be paid to the Participant if, while covered under the Plan, such Participant becomes disabled and is prevented from working at such Participant's regular occupation as the result of disability, as defined herein. No benefits are paid for partial disability.

## Pregnancy-Related Conditions

Two pregnancy-related condition are considered:

- Normal pregnancy.
- Complications from an abnormal pregnancy.

**Normal Pregnancy.** The Schedule of Benefits set forth whether benefits for normal pregnancy are covered.

**Complications from or Abnormal Pregnancy.** This will be treated as any illness and accordingly covered as such. Examples include: extra uterine pregnancy, Caesarian Section, and placenta previa, e.g. Also covered would be medical conditions associated with pregnancy. Examples include: anemia, infections of genital tract, nephritis, phlebitis, pyelitis and varicose veins.

## Determinations of Disability

For uncomplicated determinations the statement of the Participant's attending physician will suffice. If the determinations are significant in size or of likely long duration, the opinion of an independent physician should be obtained. Unless fairness to the Participant, is jeopardized, the statement of the Participant's *plan* or *corporate* physician may be used.

Ability to work in a different occupation following onset of injury or disease will not, *of itself*, defeat recovery of benefits. Ability to work in another occupation may be evidence of ability to perform duties of the occupation at onset of disability. The burden of proof of disability rests with the Participant. The Participant has the responsibility for furnishing positive evidence of disability and physician's treatment in the form of an attending physician's statement to substantiate payment of disability benefits.

## Period of Disability

Benefits for the Maximum Benefit Period, as shown in the Schedule of Benefits, are paid once during any one period of disability. Periods of disability separated by less than two (2) week's active work on full-time basis shall be considered one period of disability unless the subsequent period of disability is due to a different cause and begins after a return to the full-time duties of the participant's regular occupation for at least one full day. The participant must be under the regular care of a physician during the period for which benefits are claimed.

## Limitations and Exclusions

Benefits will not be paid for (a) disability due to bodily injuries arising from or in the course of any employment; or (b) disability due to injury, sickness or disease for which any benefits are provided under Workers' Compensation or similar laws; or (c) disability due to an accident sustained or contracted in consequence of being intoxicated or under the influence of alcohol or any narcotic unless administered on advice of a physician; or (d) disability due to injury sustained and/or sickness or disease contracted within twelve (12) months prior to the effective date of coverage unless the disability commences after a period of no less than twelve (12) months after coverage became effective; or disability which results from either a violation of the law by the Participant or is self-inflicted.

## Reduction in Benefits for Federal Taxes

To the extent that Employer monies were used to pay for short term disability benefits, to that same extent Federal Taxes are due thereon. Such taxes are of two types:

- Social Security and Medicare Taxes.
- Income taxes.

### Social Security and Medicare Taxes

The Participant's share of such taxes will be deducted (i.e., withheld) by the Plan Supervisor and benefit check reduced accordingly. The Employer will remit its share of such taxes on a quarterly basis using IRS Form 941 and data provided to it by the Plan Supervisor.

### Income Taxes

The Schedule of Benefits indicates whether this Plan, for income tax purposes only, will treat the benefits as (a) payroll or (b) welfare plan payments.

- Payroll Purposes
- Disability checks will be net of federal, and if appropriate, state taxes and an IRS Form W-2 statement provided by the Employer at the end of the calendar year.
- Welfare Plan Purposes
- Disability checks will not be net of such taxes and an IRS Form 1099 provided by the Employer at the end of the calendar year.

# VISION CARE BENEFITS

## Payment of Benefits

If a Covered Person, while covered for *Vision Care Benefits* as set forth in the Schedule of Benefits incurs Covered Vision Expenses, benefits are payable under the Plan subject to the frequency limitations and maximum set forth in this section.

## Covered Vision Expenses

Covered Vision Expenses are those incurred in connection with the following vision care services:

1. Vision examination by an ophthalmologist (or other physician licensed to perform vision examinations and prescribe lenses) or optometrist to evaluate the health and visual status of the eyes. An examination usually includes case history, visual acuity (clearness of vision), external examination and measurement, interior examination with ophthalmoscope, pupillary reflexes and eye movements, retinoscopy (shadow test), subjective refraction coordination measurements (far and near), tonometry, glaucoma test, medicating agents for diagnostic purposes, if applicable, and analysis of findings with recommendations and a prescription, if required.
2. Two glass lenses when prescribed by an ophthalmologist (or other physician licensed to perform vision examinations and prescribe lenses) or optometrist. Optionally, plastic lenses, tints, equal to tints No. 1 or No. 2, or contact lenses may be substituted for glass lenses. Lenses should meet the Z80.1 or Z80.2 standards of the American National Standards Institute.
3. Frame adequate to hold lenses.
4. Dispensing services performed by an ophthalmologist (or other physician licenses to perform vision examinations and prescribe lenses), optometrist or optician who, based on the prescription, prepares or orders the eyeglasses or contact lenses selected, verifies the accuracy of the lenses and assures that the eyeglasses or contact lenses fit properly.

## Frequency Limitations

A Covered Person had previously received a vision examination, lenses or a frame, benefits will be payable for subsequent vision examination, lenses or a frame only if two or more years have elapsed since the date of the previous examination for which benefits were paid under the Plan or the date the prior lenses or frame were ordered and for which benefits were paid under the Plan.

## Exclusions

Covered Vision Expenses do not include, and benefits are not payable for:

1. Services or supplies for which the participant is entitled to benefits under any other section of the Plan or as provided under an Employer-sponsored safety program.
2. Sunglasses (tinted lenses with a tint other than Tints No. 1 or No. 2) are considered to be sunglasses for the purpose of this exclusion unless required for albinism.
3. Extra charges for photosensitive or anti-reflective lenses.
4. Drugs or any other medication not administered for the purpose of a vision examination.
5. Medical or surgical treatment of the eye.
6. Special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids, aniseikonic lenses and tonography.
7. Vision examinations rendered and lenses or frames ordered:
  - Before the person became eligible for Vision Care Benefits.
  - After termination of Vision Care Benefits coverage.
8. Lenses or frames ordered while covered for Vision Care Benefits, but delivered more than sixty (60) days after termination of such coverage.
9. Services or supplies not prescribed as necessary by a licensed physician, optometrist or optician.
10. Replacement of lenses or frames which are lost or broken unless at the time of such replacement the Covered Person is otherwise eligible under the frequency limitation.
11. Services or supplies covered by any workers' compensation laws or employer's liability acts, or which the employer is required by law to furnish in whole, or in part.
12. Services or supplies for which no charge is made that a Covered Person is legally obligated to pay, or for which no charge would be made in the absence of Vision Care Benefits coverage.
13. Services or supplies which are obtained from any governmental agency without cost by compliance with laws or regulations enacted by any governmental body.

Note: Certain of the services and supplies excluded above may be payable under other sections of the Plan.

## PRESCRIPTION DRUG CARD PLAN

The Participant is encouraged to use a prescription drug card which will be honored by many area pharmacies. The Plan Coordinator will provide such participant with a list of area pharmacies honoring such card.

When such care is honored, the Participant need pay only a cash amount at the pharmacy; the balance is paid by the Plan at 100%. The Schedule of Benefits sets forth the Deductible Amounts for brand names and for generic prescription drugs.

When such card is **not** honored, the Participant should pay for the drugs in cash and file for reimbursement on a claim form (furnished by either your Plan Coordinator or by the Plan Supervisor). Such claim filing should include the covered drug bills and should be mailed to the Prescription Drug Card Administrator as set forth in the Schedule of Benefits.

By accepting this prescription identification card the Participant agrees to return the prescription identification card to the Employer upon the termination from this Plan. The Schedule of Benefits indicates whether or not the Plan offers a mail-order prescription drug option and the benefits and/or limitations provided. The usual rule is that supplies in excess of ninety (90) days are not covered. This benefit is suitable for maintenance medications.

### Choice of Plan Benefits

The Schedule of Benefits sets forth whether any of the above-described benefits, if offered will be offered on the basis of (a) elective by the Participant or (b) mandatory as an integral part of the health care benefit package.