
YOUR GROUP INSURANCE PLAN

MARYLAND TROOPERS ASSOCIATION

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IMPORTANT NOTICE

The dental expense benefits provided by this plan are funded solely by the Maryland Troopers Association. The benefits are not guaranteed by a policy of insurance issued by Guardian. Guardian does supply administrative services, such as claims services, including the payment of claims, preparation of member benefit booklets and changes to such benefit booklets.

B115.0113-R

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002-R

Member Coverage

Eligible Members To be eligible for *member* coverage you must belong to a class of *members* covered by this *plan*.

Other Conditions If you must pay all or part of the cost of *member* coverage, we won't insure you until you enroll and agree to make the required payments. If you do this: (a) more than 90 days after you first become eligible; or (b) after you previously had coverage which ended because you failed to make a required payment, we consider you to be a late entrant.

If you initially waived dental coverage under this *plan* because you were covered under another group *plan*, and you now elect to enroll in the dental coverage under this *plan*, the Penalty for Late Entrants provision will not apply to you with regard to dental coverage provided your coverage under the other *plan* ends due to one of the following events: (a) termination of your spouse's employment; (b) loss of eligibility under your spouse's *plan*; (c) divorce; (d) death of your spouse; or (e) termination of the other *plan*.

But you must enroll in the dental coverage under this *plan* within 90 days of the date that any of the events described above occur.

B489.0122-R

When Your Coverage Starts *Member* benefits are scheduled to start on your effective date.

B489.0069-R

When Your Coverage Ends Your coverage ends on the date your membership ends for any reason.

It also ends on the date you stop being a member of a class of *members* eligible for coverage under this *plan*, or when this *plan* ends for all *members*. And it ends when this *plan* is changed so that benefits for the class of *members* to which you belong ends.

If you are required to pay all or part of the cost of this coverage and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

Read this booklet carefully if your coverage ends. You may have the right to continue certain group benefits for a limited time.

B489.0087-R

Dependent Coverage

B200.0271-R

Eligible Dependents For Dependent Dental Benefits Your *eligible dependents* are: (a) your legal spouse; (b) your unmarried dependent children who are under age 19; (c) your unmarried dependent children, from age 19 until their 25th birthday, throughout the month of graduation, who are enrolled as full-time students at accredited schools; (d) your unmarried dependent grandchildren who are under age 19, who are your dependents and in your court-ordered custody; and (e) your unmarried dependent grandchildren, from age 19 until their 25th birthday, throughout the month of graduation, who are enrolled as full-time students at accredited schools and are your dependents and in your court-ordered custody.

B200.0511-R

Adopted Children And Step-Children Your "unmarried dependent children" include your legally adopted children and, if they depend on you for most of their support and maintenance, your step-children. We treat a child as legally adopted from the time the child is placed in your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

Dependents Not Eligible We exclude any dependent who is covered by this *plan* as an *member*. And we exclude any dependent who is on active duty in any armed force.

B264.0007-R

Handicapped Children You may have an unmarried child or grandchild with a mental or physical handicap, or developmental disability, who can't support himself or herself. Subject to all of the terms of this coverage and the *plan*, such a child may stay eligible for dependent benefits past this coverage's age limit.

The child will stay eligible as long as he or she stays unmarried and unable to support himself or herself, if: (a) his or her conditions started before he or she reached this coverage's age limit; (b) he or she became covered by this coverage before he or she reached the age limit, and stayed continuously covered until he or she reached such limit; and (c) he or she depends on you for most of his or her support and maintenance. With respect to a grandchild, the grandchild must also remain your dependent and in your court-ordered custody in order to stay eligible.

But, for the child to stay eligible, you must send us written proof that the child is handicapped and depends on you for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, we can't ask for this proof more than once a year.

The child's coverage ends when yours does.

B449.0043-R

Waiver Of Dental Late Entrants Penalty If you initially waived dental coverage for your spouse or eligible dependent children under this plan because they were covered under another group plan, and you now elect to enroll them in the dental coverage under this plan, the Penalty for Late Entrants provision will not apply to them with regard to dental coverage provided their coverage under the other plan ends due to one of the following events: (a) termination of your spouse's employment; (b) loss of eligibility under your spouse's plan; (c) divorce; (d) death of your spouse; or (e) termination of the other plan.

Dependent Coverage (Cont.)

But you must enroll your spouse or eligible dependent children in the dental coverage under this plan within 90 days of the date that any of the events described above occur.

In addition, the Penalty for Late Entrants provision for dental coverage will not apply to your spouse or eligible dependent children if: (a) you are under legal obligation to provide dental coverage due to a court-order; and (b) you enroll them in the dental coverage under this plan within 90 days of the issuance of the court-order.

B200.0749-R

When Dependent Coverage Starts

In order for your dependent coverage to begin you must already be covered for member coverage or enroll for member and dependent coverage at the same time. Subject to the "Exception" stated below and to all of 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.

If you do this on or before your *eligibility date*, the dependent's coverage is scheduled to start on the later of your *eligibility date* and the date you become covered for member coverage.

If you do this within the *enrollment period*, the coverage is scheduled to start on the later of the date you sign the enrollment form; and the date you become covered for member coverage.

If you do this after the *enrollment period* ends, each of your *initial dependents* is a late entrant and is subject to any applicable late entrant penalties. The dependent's coverage is scheduled to start on the date you sign the enrollment form.

Once you have dependent coverage for your *initial dependents*, you must notify us when you acquire any new dependents, other than a newborn child, and agree to make any additional payments required for their coverage. See the "Newborn Children" provision to find out when you must notify us of a newborn child.

If you do this within 90 days of the date the *newly acquired dependent* becomes eligible, the dependent's coverage, other than that of a newborn child, will start on the date the dependent first becomes eligible. If you fail to notify us on time, the *newly acquired dependent*, when enrolled, is a late entrant and is subject to any applicable late entrant penalties. The late entrant's coverage is scheduled to start on the date you sign the enrollment form.

B489.0058-R

Exception

If a dependent, other than a newborn child, is confined to a *hospital* or other health care facility on the date his dependent benefits would otherwise start, we will postpone the effective date of such benefits until the day after his discharge from such facility.

B200.0694-R

Newborn Children We cover your newborn child for dependent benefits, from the moment of birth if you are already covered for dependent child coverage when the child is born. If the newborn is your first eligible dependent or you are only covered for dependent spouse coverage when the child is born, we cover the child for the first 90 days from the moment of birth. To continue the child's coverage past the 90 days, you must enroll the child and agree to make any required payment within 90 days of the date the child is born. If you fail to do this, the child's coverage will end at the end of the 90 days, and once the child is enrolled, the child is a late entrant, is subject to any applicable late entrant penalties, and will be covered as of the date you sign the enrollment form.

We also cover your newborn grandchild for dependent benefits from the moment of birth, if the child is a dependent of and in the court-ordered custody of you.

B489.0013-R

When Dependent Coverage Ends Dependent coverage ends for all of your dependents when your coverage ends. But if you die while covered, we'll automatically continue dependent benefits for those of his or her dependents who were covered when you died. We'll do this for six months at no cost, provided: (a) the group plan remains in force; (b) the dependents remain *eligible dependents*; and (c) in the case of a spouse, the spouse does not remarry.

If a surviving dependent elects to continue your dependent benefits under this *plan's* "Federal Continuation Rights" provision, or under any other continuation provision of this *plan*, if any, this free continuation period will be provided as the first six months of such continuation. Payments required to be paid by, or on behalf of a surviving dependent will be waived for the first six months of continuation, subject to restrictions (a), (b) and (c) above. After the first six months of continuation, the remainder of the continuation period, if any, will be subject to the payment requirements, and all of the terms of the "Federal Continuation Rights" or other continuation provisions.

Dependent coverage also ends for all of your dependents when you stop being a member of a class of *members* eligible for such coverage. And it ends when this *plan* ends, or when dependent coverage is dropped from this *plan* for all *members* or for an *member's* class.

If you are required to pay all or part of the cost of dependent coverage, and you fail to do so, your dependent coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

Dependent Coverage (Cont.)

An individual dependent's coverage ends when he or her stops being an *eligible dependent*. This happens to a child, step-child or grandchild on the last day of the year in which he or she turns age 19, or on the last day of the month in which a dependent who is a full-time student turns age 25. A step-child's coverage also ends when he or she is no longer dependent on you for support and maintenance. A grandchild's coverage also ends when he or she is no longer a dependent of and in the court-ordered custody of you. And a spouse's coverage ends when a marriage ends in legal divorce or annulment. An individual dependent's coverage also ends when he or she marries.

Read this *plan* carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time.

B489.0045-R

DENTAL HIGHLIGHTS

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

- **Cash Deductible for Non-Orthodontic Services**

Lifetime deductible for Group I and II Services \$50.00
for each covered person

Annual deductible for Group III Services \$50.00
for each covered person

- **Lifetime Cash Deductible for Orthodontic Services**

For Group IV Services \$50.00
for each covered person

- **Payment Rates:**

For Group I Services 100%

For Group II Services 80%

For Group III Services 50%

For Group IV Services 50%

- **Benefit Year Payment Limit for Non-Orthodontic Services**

For Group I, II and III Services Up to \$1,500.00

- **Lifetime Payment Limit for Orthodontic Treatment**

For Group IV Services Up to \$1,500.00

DENTAL EXPENSE Coverage

This coverage will pay many of your and your covered dependents' dental expenses. What we pay and the terms for payment are explained below.

B490.0036-R

Covered Charges

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

By reasonable, we mean the charge is the *dentist's* usual charge for the service furnished. By customary, we mean the charge made for the given dental condition isn't more than the usual charge made by most other *dentists*. But, in no event will the covered charge be greater than the 80th percentile of the HIAA Prevailing Fee, or a similar standard, for a particular service in a geographic area. When routinely associated procedures are performed on the same day, the covered charge will be for the most comprehensive procedure.

We only pay for covered charges that commence while a *covered person* is covered. 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. A covered charge for *orthodontic treatment* is incurred on the date the active *appliance* is first placed. All other covered charges are incurred on the date the services are furnished.

B497.0688-R

Alternate Treatment

If more than one type of service can be used to treat a dental condition, we have 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 to accurately pay for and determine covered charges, it is required that information acceptable to The Insurance Company be provided. This information shall consist of x-rays, study models, narratives or other diagnostic materials. If the necessary information is not provided, no benefit or minimum benefits may be allowable. However, if accepted necessary information is provided later, benefits will be redetermined based on the new information.

B497.0005-R

Pre-Treatment Review

When the expected cost of a proposed course of treatment is \$300.00 or more (\$200.00 for periodontic treatment), the *covered person's dentist* must send us a treatment plan before he or she starts. This must be done on a form acceptable to The Insurance Company. 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 we need to evaluate the treatment plan must be sent to us, too.

A treatment plan must always be sent to us before *orthodontic treatment* starts.

We review the treatment plan and estimate what we will pay. The estimate will be sent to the *covered person's dentist*. If we don't agree with a treatment plan, or if one is not sent in, we have the right to base our payments on treatment suited to the *covered person's* condition by accepted standards of dental practice.

Pre-treatment review is not a guarantee of what we will pay. It tells the *covered person* and his or her *dentist*, in advance, what we would pay for the covered dental services named in the treatment plan. But payment is conditioned on: (a) the work being done as proposed and commencing while the *covered person* is covered; and (b) the deductible and payment limit provisions and all of the other terms of this *plan*.

Emergency treatment, oral examinations, dental X-rays and teeth cleaning are part of a course of treatment, but may be done before the pre-treatment review is made.

We won't deny benefits if pre-treatment review is not done. But, what we pay will be based on the availability and submission of *proof of claim*.

B497.0692-R

Benefits From Other Sources

Other plans may furnish similar benefits, too. For instance, you may be covered by this *plan* and a similar plan through your spouse's employer. If you are, we coordinate our benefits with the benefits from these other plans. We do this so no one gets more in benefits than the charges he incurs.

B497.0437-R

Extended Dental Expense Benefits

If a *covered person's* coverage ends, we extend dental expense benefits for that *covered person* under this *plan* as explained below.

We only extend benefits for covered charges for a dental procedure, if the procedure: (a) is begun before the *covered person's* coverage ends; and (b) requires two or more visits on separate days to a dentist's office.

Extended Dental Expense Benefits (Cont.)

With respect to non-orthodontic procedures, benefits will be paid until the earlier of: (a) when all work is completed; or (b) 90 days after the date the *covered person's* coverage ends.

With respect to orthodontic procedures, benefits will be paid for work: (a) performed within 60 days of the date the *covered person's* coverage ends if the orthodontist has agreed to or is receiving monthly payments for his services at the time coverage ends; or (b) performed by the end of the quarter in progress or within 60 days of the date the *covered person's* coverage ends, whichever is longer, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

We don't grant an extension if the person's coverage ended because he failed to make required payments.

B497.0055-R

The Benefit Provision - Qualifying For Benefits

The following "Waiting Period for Certain Services" provision applies only to covered persons who become covered for dental coverage under this plan after February 1, 2002:

Waiting Period For Certain Services

When a *covered person* is first covered by this *plan*, we won't pay for the following dental services until the applicable waiting periods are completed. We won't pay for Group III services until a *covered person* has been covered by this *plan* for 6 months. We won't pay for Group IV *orthodontic treatment* until a *covered person* has been covered by this *plan* for 18 months.

Charges incurred during the waiting periods are not considered covered dental services and cannot be used to satisfy this *plan's* deductibles.

All *covered persons* except late entrants are subject to these waiting periods. Late entrants are subject to the applicable penalty provision shown in the "Special Limitations" provision.

B497.0613-R

Group I, II And III Non-Orthodontic Services

A lifetime deductible of \$50.00 applies to Group I and II services. An annual deductible of \$50.00 applies to Group III services. Each *covered person* must have covered charges from these groups which exceed this deductible before we pay him or her any benefits for such charges. These charges must commence while the *covered person* is covered.

Once a *covered person* meets these deductible, we pay for his or her Group I, II and III covered charges above that amount at the applicable payment rates.

All charges must commence while the *covered person* is covered. We limit what we pay each *benefit year* to \$1,500.00. What we pay is based on all of the terms of this *plan*.

B497.0698-R

The Benefit Provision - Qualifying For Benefits (Cont.)

Group IV Orthodontic Services This *plan* provides benefits for Group IV orthodontic services only for covered dependent children who are less than 18 years old when the active *appliance* is first placed.

We pay for Group IV covered charges at the applicable payment rate. Using the treatment plan, we calculate the total benefit we will pay. We divide this into equal payments, which we spread out over the shorter of two years or the proposed length of treatment.

We make the initial payment when the active *appliance* is first placed. We make further payments at the end of each subsequent three month period. But treatment must continue and the *covered person* must stay covered, except as specified in the "Extended Dental Expense Benefits" section of this plan. And we limit what we pay during a covered person's lifetime to \$1,500.00. What we pay is based on all of the terms of this *plan*.

A lifetime deductible of \$50.00 applies to Group IV services. Each covered person must have covered charges from this group which exceed this deductible before we pay him any benefits for these charges.

Orthodontic benefits won't be charged against the *benefit year* payment limit which applies to all other services.

B497.0713-R

Payment Rates Benefits for covered charges are paid at the following rates:

Benefits for Group I Services are paid at a rate of 100%

Benefits for Group II Services are paid at a rate of 80%

Benefits for Group III Services are paid at a rate of 50%

Benefits for Group IV Services are paid at a rate of 50%

B497.0029-R

Special Limitations

The following "Penalty For Late Entrants" provision applies only to covered persons who become covered for dental coverage under this plan after February 1, 2002:

Penalty For Late Entrants We won't cover charges incurred by a late entrant for: (a) Group II Services until 6 months from the date he is covered by this *plan*; and (b) Group III Services until 18 months from the date he is covered by this *plan*; and (c) Group IV Services until 24 months from the date he is covered by this plan.

However, this limitation will not apply to *covered charges* due solely to an *injury* suffered while covered.

Charges not covered due to this provision are not considered covered dental services and cannot be used to satisfy this *plan's* deductible.

A late entrant is a person who: (1) becomes covered more than 31 days after he is eligible; or (2) becomes covered again, after his coverage lapsed because he did not make required payments.

The following "Penalty For Late Entrants" provision applies only to covered persons who become covered for dental coverage under this plan on or before February 1, 2002:

Penalty For Late Entrants We won't cover charges incurred by a late entrant for: (1) Group II services until 6 months from the date he is covered by this *plan*; (2) Group III services until 12 months from the date he is covered by this *plan*; and (3) *Group IV orthodontic treatment* done in the first 24 months he is covered by this *plan*. However, this limitation will not apply to covered charges due solely to an *injury* suffered while covered.

Charges not covered due to this provision are not considered covered dental services and cannot be used to satisfy this *plan's* deductibles.

A late entrant is a person who: (1) becomes covered more than 31 days after he is eligible; or (2) becomes covered again, after his coverage lapsed because he did not make required payments.

B497.0850-R

Teeth Lost Or Missing Before A Covered Person Becomes Covered By This Plan A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became covered by this *plan*. We won't pay for a *prosthetic device* which replaces such teeth unless: (a) the device also replaces one or more natural teeth lost or extracted after the covered person became covered by this *plan*; or (b) the covered person has been covered by this plan for at least 5 years.

If This Plan Replaces Another Plan This *plan* may be replacing another plan your *employer* had with some other insurer.

We don't want anyone to lose benefits when this happens. So we pay for certain charges incurred before this *plan* starts, if: (1) the covered person was covered by the old *plan*; and (2) the old *plan* would have paid for such charges. But this *plan* must start right after the old *plan* ends. And the covered person must be covered by this *plan* from the start.

We limit what we pay to the lesser of: (1) what the old *plan* would have paid; or (2) what we would otherwise pay. And we deduct any benefits actually paid by the old *plan* under any extension provision.

In the first *benefit year* of this *plan*, we also reduce this *plan's* deductibles by the amount of covered charges applied against the old *plan's* deductible. And, in the first *benefit year*, we charge benefits which were paid by the old *plan* against this *plan's* payment limits.

B497.0729-R

- We won't pay for:
 - Oral hygiene, plaque control or diet instruction.
 - Precision attachments.
 - Desensitizing medicaments.
 - Prescription medication.
- We won't pay for:
 - Treatment which does not meet accepted standards of dental practice.
 - Treatment which is experimental in nature.
- We won't pay for any *appliance* or *prosthetic device* used to:
 - Change vertical dimension.
 - Restore or maintain occlusion, except to the extent that this *plan* covers *orthodontic treatment*.
 - Splint or stabilize teeth for periodontic reasons.
 - Replace tooth structure lost as a result of abrasion or attrition.
- We won't pay for any service furnished for cosmetic reasons. This includes, but is not limited to:
 - Characterizing and personalizing *prosthetic devices*.
 - Making facings on *prosthetic devices* for any teeth in back of the second bicuspid.

However, we will pay benefits for covered charges for cosmetic surgery needed due to conditions following trauma.

- We won't pay for replacing an *appliance* or *prosthetic device* or processed veneer with a like appliance or device, unless:
 - It is at least five years old and can't be made usable.
 - It is damaged while in the *covered person's* mouth in an *injury* suffered while covered, and can't be made serviceable.
- We won't pay for any service, appliance, device or modality intended to treat disturbances of the temporo-mandibular joint.
- We won't pay for:
 - Replacing a lost, stolen or missing *appliance* or *prosthetic device*.
 - Making a spare *appliance* or device.
- We won't pay for:
 - Implants.
 - Tooth transplants.
 - Surgical repositioning of the jaw.
- We won't pay for treatment needed due to:
 - An on-the-job or job-related injury.
 - A condition for which benefits are payable by Worker's Compensation or similar laws.

Exclusions (Cont.)

- We won't 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 we are legally required to pay it, we will.
- We won't pay for overdentures.

B497.0737-R

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 four groups. A separate payment rate applies to each group. Group I is made up of preventive services. Group II is made up of basic services. Group III is made up of major services. Group IV is made up of orthodontic services.

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.

B490.0048-R

Group I - Preventive Dental Services (Non-Orthodontic)

Prophylaxis And Fluoride Treatments Prophylaxis, including periodontal prophylaxis (Topical application of fluoride is limited to *covered persons* under age 18 and limited to one treatment in any six consecutive month period) - Allowance includes examination, scaling and polishing.

Office Visits And Examinations Initial or periodic oral examination (limited to one examination in any 12 consecutive month period).

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

B497.0982-R

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.

Group I - Preventive Dental Services (Cont.)

(Non-Orthodontic)

Fixed And Removable Appliances To Inhibit Thumbsucking - (limited to covered persons under age 14 and limited to initial appliance only) - Allowance includes all adjustments in the first 6 months after installation.

B497.0298-R

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, within 30 days of 36 months).
 - Bitewing films (limited to a maximum of four films in one visit, in any 12 consecutive month period, within 14 days of the year).
 - Other intraoral periapical or occlusal films - single films (limited to 4 periapical & 2 occlusal in any 12 consecutive month period).
 - Extraoral superior or inferior maxillary film (limited to 2 in any 12 consecutive month period).
 - Panoramic film, maxilla and mandible.

B497.0761-R

Dental Sealants Posterior Teeth

- Topical application of sealant (limited to the unrestored permanent molar teeth of *covered persons* under age 16 and limited to one treatment per tooth in any 24 consecutive month period).

B497.0981-R

Group II - Basic Dental Services

(Non-Orthodontic)

Office Visits And Examinations Diagnostic consultation with a dentist other than the one providing treatment (limited to one consultation for each dental specialty in any 12 consecutive month period) - We pay 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.

Group II - Basic Dental Services (Cont.)
(Non-Orthodontic)

Restorative Services Multiple restorations on one surface will be considered one restoration. Also see "Major Restorative Services".

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

B497.0306-R

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.

B497.0308-R

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.

B497.0313-R

Group II - Basic Dental Services (Cont.)

(Non-Orthodontic)

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

- 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.
- Nitrous oxide for children age 5 or younger.

B497.0315-R

Group III - Major Dental Services

(Non-Orthodontic)

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 Service 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 "Major Restorative Services".

Group III - Major Dental Services (Cont.)

(Non-Orthodontic)

- 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 60 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).

B497.0317-R

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.)

Group III - Major Dental Services (Cont.) (Non-Orthodontic)

- Gingivectomy, per tooth (fewer than 6 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.
- Occlusal adjustment, not involving restorations and done in conjunction with periodontic surgery, per quadrant (limited to a maximum of 4 quadrants in any 36 consecutive month period).

B497.0319-R

Group IV - Orthodontic Services

- Orthodontic Services**
- Any Group I, II or III service in connection with *orthodontic treatment*.
 - Surgical exposure of impacted or unerupted teeth in connection with *orthodontic treatment* - Allowance includes routine x-rays, local anesthetics and post-surgical care.
 - Active *appliances* - All types - Allowance includes diagnostic services, the treatment plan, the fitting, making and placing of the active *appliance*, and all related office visits including post-treatment stabilization.

B490.0052-R

COORDINATION OF BENEFITS

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

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

Definitions "We" and "our" mean The Insurance Company as Claims Administrator.

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

- (A) group, blanket, or franchise coverage 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, member benefits plans, trustee labor and management plans, or other plans for members of a group;
- (D) programs or coverages required or provided by law, except for personal injury protection benefits which applicable state or federal law requires to be afforded without regard to fault under motor vehicle coverage policies.

"Plan" does not include Medicaid or any other government program or coverage which we are not allowed to coordinate with by law. Nor does it include any plan we say we supplement. Plans that we supplement are named in the schedule.

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

"Member" means the person who receives a evidence of coverage 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 necessary, reasonable, and usual expense for health care incurred by a member or dependent under (a) this plan, or (b) one of the other plans. When a plan provides service instead of cash payment, we view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view 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 We apply this provision when a member or dependent is covered by more than one plan. When this happens we consider 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 before a plan that covers such person as a dependent;
- (B) A plan that covers a person as an active member or as a dependent of such member pays before a plan that covers such person as a laid-off or retired member or as a dependent of such member .

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

- (C) 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. Except that if both members have the same birthday, the plan which has covered a member for the longer time pays first. The member's year of birth is ignored.

But, if the plan that we're coordinating with does not have a similar provision for such persons, then (C) will not apply and the other plans coordination provision will determine the order of benefits.

- (D) 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:

- 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;
- 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; and
- The plan of the stepparent with custody pays before the plan of the natural parent without custody.

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

Coordination of Benefits (Cont.)

If, when we apply this provision, we pay less than we would otherwise pay, we apply only that reduced amount against payment limits of this plan.

B550.0060-R

Our Right To Certain Information In order to coordinate benefits, we need certain information. An member must supply us with as much of that information as he or she can. But if he or she can't give us all the information we need, we have the right to get this information from any source. And if another insurer needs information to apply its coordination provision, we have the right to give that insurer such information. If we give or get information under this section, we can't be held liable for such action.

When payments that should have been made by this plan have been made by another plan, we have the right to repay that plan. If we do so, we're no longer liable for that amount. And if we pay out more than we should have, we have the right to recover the excess payment.

Small Claims Waiver We don'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, we'll count the entire amount of the claim when we coordinate.

B555.0057-R

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

B900.0118-R

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

B750.0292-R

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

B750.0193-R

Benefit Year with respect to this *plan's* dental expense coverage, means a 12 month period which starts on February 1st and ends on January 31st.

B750.0444-R

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. We don't pay for services and supplies furnished by *close relatives*.

B750.0195-R

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

B750.0196-R

Dentist means any dental or medical practitioner we are 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 evidence of coverage and covered by this *plan*.

B750.0198-R

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

B900.0003-R

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

B750.0015-R

Member means a person who is a participant in the Association.

B750.0006-R

Employer means MARYLAND TROOPERS ASSOCIATION .

B900.0051-R

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.

B900.0004-R

Initial Dependents means those *eligible dependents* you have at the time you first become eligible for *member 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*.

B900.0006-R

Injury means all damage to a covered person's mouth due to an accident, and all complications rising from that damage.

B750.0442-R

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

B900.0008-R

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.

B750.0201-R

Plan means the *plan* purchased by your *Association*, except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.

B900.0039-R

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.

B750.0294-R

STATEMENT OF ERISA RIGHTS

As a participant you are entitled to certain rights and protection under the Member Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- (a) examine, without charge, all plan documents, including coverage contracts, collective bargaining agreements and copies of all documents filed by the plan with the U. S. Department of Labor, such as detailed annual reports and plan descriptions. The documents may be examined at the Plan Administrator's office and at other specified locations such as worksites and union halls.
- (b) obtain copies of all plan documents and other plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies; and
- (c) receive a summary of the plan's annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people, called "fiduciaries", who are responsible for the operation of the member benefit plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. Your employer may not fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, you may file suit in a federal court if you request materials from the plan and do not receive them within 30 days. The court may require the plan administrator to provide the materials and pay you up to \$110.00 a day until you receive them (unless the materials were not sent because of reasons beyond the administrator's control). If your claim for benefits is denied in whole or in part, or ignored, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against you for asserting your rights, you may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If you are successful, the court may order the person you have sued to pay court costs and legal fees. If you lose, the court may order you to pay; for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

B800.0050-R

The Insurance Company's Responsibilities

B800.0048-R

The dental expense benefits provided by this plan are self-covered by the employer. The benefits **are not** guaranteed by a policy of coverage issued by The Insurance Company. The Insurance Company does supply administrative services, such as claims services, including the payment of claims, preparation of member evidence of coverage, and changes to such evidence of coverage.

B800.0054-R

The Insurance Company is located at 7 Hanover Square, New York, New York 10004.

B800.0049-R

Claims Procedure

Claim forms and instructions for filing claims may be obtained from the Plan Administrator. Completed claim forms and any other required material should be returned to the Plan Administrator for submission to The Insurance Company.

The Insurance Company is the Claims Administrator with respect to processing claims. The Plan Administrator has discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in your benefit booklet, The Insurance Company will also observe the procedures listed below. All notification from The Insurance Company will be in writing.

- (a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 90 days after The Insurance Company received the claim.
- (b) If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which The Insurance Company expects to render the final decision.

Claims Procedure (Cont.)

- (c) If a claim is denied, The Insurance Company will provide to the Plan Administrator, for delivery to the claimant, a notice that will set forth:
- (1) the specific reason(s) the claim was denied;
 - (2) specific references to the pertinent *plan* provision on which the denial is based;
 - (3) a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
 - (4) an explanation of the *plan's* claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

- (d) The Insurance Company will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, The Insurance Company will render a decision as soon as possible, but no later than 120 days after receiving the request. The Insurance Company will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.

B800.0032-R

Termination of This Group Plan

Your *Association* 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.

B800.0007-R